

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

02396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02383

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>MINUTES</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>100 BLOCK N. JONATHAN STREET</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission) e. STATE <b>MARYLAND</b> f. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>122 ROSS STREET</b> d. STREET ADDRESS <b>122 ROSS STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>NMN</b> Last <b>AKOWSKY</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>23</b> Year <b>1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 13 1896</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>METAL SORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SALVAGE COMPANY</b>		9. AGE (In years last birthday) <b>65</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>UNKNOWN</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or details of service)			
16. SOCIAL SECURITY NO. <b>214-09-0717</b>				17. INFORMANT <b>CARL F AKOWSKY</b> Address <b>3800 81st AVENUE WASHINGTON D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 420.1 DUE TO <b>Obstruction of Coronary Arteries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ascending Branch Left Coronary Artery</b> (c) <b>Coronary Arteriosclerosis Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>instant</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>A. E. W. Ditto Jr.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2-26-62</b> EXAMINER'S NAME (Type) <b>E.W. DITTO JR. M. D.</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>215 W WASHINGTON ST. HAGERSTOWN MARYLAND</b> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-27-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL'S CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>WILSON DISTRICT MARYLAND</b>	
23. FUNERAL DIRECTOR <b>SUTER-ROUZER FUNERAL HOME</b> ADDRESS <b>HAGERSTOWN MD</b>				24a. REC'D BY REGISTRAR <b>MAR 1 '62</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

MEDICAL CERTIFICATION

UNITED STATES  
DEPARTMENT OF JUSTICE



02332

02332

ALABAMA STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

TO BE FILLED BY THE MEDICAL EXAMINER  
[illegible text]

1-3-32  
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02384

02397

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b> c. LENGTH OF STAY IN life <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock Maryland</b> d. STREET ADDRESS <b>104 Fairview Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elizabeth Motten Allen</b>				4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>19 62</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>B</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1.14.1874</b>	
9. AGE (In years last birthday) <b>88</b> yrs.				IF UNDER 1 YEAR Months <b>22</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>62</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hancock Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Not Known</b>			
14. MOTHER'S MAIDEN NAME <b>Not Known</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Burman Allen Hancock Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause on line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ch. Myocarditis</b> <b>59 2X</b> DUE TO <b>Ch. nephritis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>similarity</b> (b) <b>similarity</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 Wks</b> <b>11</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 21 62</b> to <b>Feb 22 62</b> , that (I) <b>just</b> last saw the deceased alive on <b>Feb 21 19 62</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>E. M. Shaffer</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>E. M. SHAFER</b>	
22d. ADDRESS <b>Hancock Md.</b>				22e. REC'D BY REGISTRAR			
22f. REGISTRAR'S SIGNATURE				22g. DATE <b>FEB 27 '62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2.24.62</b>		23c. NAME OF CEMETERY OR <del>CREMATORY</del> <b>Riverview</b>		23d. LOCATION (City, town or county) (State) <b>Hancock Washington Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Hancock &amp; Stone Hancock Md</b>				25a. REC'D BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>				25c. DATE <b>FEB 27 '62</b>			

02384

CENTRAL OF MARY

02384



Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

88

1.1.1.1

88

88

88

Washington

Washington

Washington

Washington

Washington



Ch. Proprietary  
Ch. Proprietary  
Ch. Proprietary

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>224 S. MULBERRY ST.</b>				d. STREET ADDRESS <b>226 S. MULBERRY ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARY ALBERTA ANDREWS</b>				<b>4. DATE OF DEATH</b> <b>FEBRUARY 23 1962</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>6/3/1888</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HOME</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM BOWERS</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>IDA McCALL</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MR. C. FRANK ANDREWS</b> Address <b>HAGERSTOWN MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>4-20-00</b> DUE TO <b>Coronary thrombosis</b> <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (b) DUE TO (e), stating the underlying cause last. (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 minutes</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Cerebral arteriosclerosis; Cholelithiasis</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>6 a.m.</b> <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 9-7-1957, 19 to death, 19, that (I) (we) last saw the deceased alive on 2-12-62, 19, and that death occurred at 1:45 PM from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Paul Harrison</i> <b>Paul Harrison</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2-24-62</b>	
<b>22c. PHYSICIAN'S NAME (Type or print)</b> <b>Robert F. Keadle</b>				<b>22d. ADDRESS</b> <b>Hagerstown, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>2/26/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL CEM.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>HAGERSTOWN MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. J. Hornum</i> <b>W. J. Hornum</b>				<b>ADDRESS</b> <b>Hagerstown, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 27 '62</b>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hume</i>			

M

02338

02338

CERTIFICATE OF DEATH

DIVISION OF HEALTH DEPARTMENT OF NEW YORK

1915

DEATH

1915

1915

Coronary thrombosis  
Atherosclerosis heart disease

Coronary arteriosclerosis; Cholelithiasis

8-2-1915

8-13-15

8-24-15

Haverhill, MA

John F. Kelle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02399 CERTIFICATE OF DEATH 02387

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pinesburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pinesburg	
c. LENGTH OF STAY IN 1b 50 yrs.		d. STREET ADDRESS Williamsport RFD #1 Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Katherine Banzhoff		4. DATE OF DEATH Month Day Year Feb. 20 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22 1874
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 5 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Unger		14. MOTHER'S MAIDEN NAME Elizabeth Burger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Pinesburg #1 Mr. Keller Banzhoff Williamsport Md RFD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 AC. MY CARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/20/62 to 2/20/62, that (I) (we) last saw the deceased alive on 2/20/62, and that death occurred at 2/20/62 M, from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young		22b. ADDRESS WILLIAMSPORT, MARYLAND	
22c. PHYSICIAN'S NAME (Type) RALPH F. YOUNG		22d. ADDRESS WILLIAMSPORT, MARYLAND	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 23-62	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	23d. LOCATION (City, town or county) (State) Williamsport Md.
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Loef Williamsport, Md		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

02387

CERTIFICATE OF DEATH

02387

Washington  
Maryland  
50 yrs.  
Williamport and  
Mary  
Feminie  
George  
Elizabeth  
Aug. 22 1894  
U.S.A.

*The wife of the deceased*

*George*  
*Elizabeth*  
*Williamport*  
*Aug. 22 1894*  
*U.S.A.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02400

## CERTIFICATE OF DEATH

02388

Item 8 Film G308 2/28/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>2 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>514 North Mulberry Street</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>514 North Mulberry Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>N. M. N.</b> Last <b>BENNETT</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>21</b> Year <b>19 62</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1889</b> 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <b>72</b> yrs. Months <b>7</b> Days <b>21</b> Hours <b>19</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard Conductor W.M. RR Retired</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or Foreign Country) <b>W. Va.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Ella Pope</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>705-10-5292</b>		17. INFORMANT <b>Donald Bennett</b> Address <b>1948 W. Washington st Hagerstown Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> 420.0 DUE TO <b>Chr Conjestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriorsclerotic heart disease</b> DUE TO (c) <b>Arteriorsclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>months</b> <b>yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> 19 p.m. <b>none</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b> (County) <b>-</b> (State) <b>-</b>	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Aug. 1961</b> to <b>Feb 21</b> , 19 <b>62</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Feb. 21</b> , 19 <b>62</b> , and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold R. Tritch Jr</b> 22c. PHYSICIAN'S NAME (Type) <b>Harold R. Tritch, Jr. M.D</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>302 N. Potomac Street- Hagerstown, Md</b> 22b. DATE SIGNED <b>2-22-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/24/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) <b>Hagerstown, Md.</b> (State) <b>-</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 26 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

VR A15 (4)  
15M 9/60



08380

0043

(M)

(1)

Andrew L. Corbett, Haverhill, MA.

Serial 0043, Case 0043, Haverhill, MA.

08380, 0043, Haverhill, MA.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02389

02401

1. PLACE OF DEATH a. COUNTY <b>Washington County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>West Virginia</b> b. COUNTY <b>Berkeley</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport, Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Sanitarium</b>				d. STREET ADDRESS <b>512 West Martin Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Meveral Clagett Blondel</b>				4. DATE OF DEATH Month Day Year <b>February 23, 1962</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1872 December 28, 1962</b>		9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>10 23 10 15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Interwoven Stocking Company</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Richard Anthony Blondel</b>				14. MOTHER'S MAIDEN NAME <b>Clara Huber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Martinsburg, W.V.</b> <b>Mrs. Mary C. Blondel, 512 W. Martin Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>5 yrs plus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs (?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophy of the prostate</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1965</b> , 19____, to <b>Feb. 23, 1962</b> , that I last saw the deceased alive on <b>Feb. 13, 1962</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Walter H. Shealy</b> DATE SIGNED <b>2/24/62</b>							
ACTUAL SIGNATURE <b>Walter H. Shealy</b>		M.D. <b>Sharpsburg Maryland</b>					
PHYSICIAN'S NAME (Type) <b>Dr. Walter H. Shealy</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>23 Feb. 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale cemetery</b>		22d. LOCATION (City, town, or county) <b>Martinsburg, W.Va.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith H. Long</b>				ADDRESS <b>Williamsport</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 26 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

CERTIFICATE OF DEATH

1961

(M)

PLACE OF BIRTH Baltimore, Maryland		COUNTY Baltimore	
DATE OF BIRTH 1910		SEX Male	
OCCUPATION Retired Interoven Bookbinding Company		MARITAL STATUS Single	
ADDRESS 515 West Martin Street Baltimore, Maryland		DATE OF DEATH 1961	
CAUSE OF DEATH (To be filled in by physician or coroner)		PLACE OF DEATH Baltimore, Maryland	
SIGNATURE OF PHYSICIAN OR CORONER (To be filled in by physician or coroner)		SIGNATURE OF REGISTRAR (To be filled in by registrar)	
NAME OF REGISTRAR (To be filled in by registrar)		ADDRESS OF REGISTRAR (To be filled in by registrar)	
NAME OF DECEASED Richard Anthony Blonkel		DATE OF BIRTH 1910	
ADDRESS OF DECEASED 515 West Martin Street Baltimore, Maryland		DATE OF DEATH 1961	
CAUSE OF DEATH (To be filled in by physician or coroner)		PLACE OF DEATH Baltimore, Maryland	
SIGNATURE OF PHYSICIAN OR CORONER (To be filled in by physician or coroner)		SIGNATURE OF REGISTRAR (To be filled in by registrar)	
NAME OF REGISTRAR (To be filled in by registrar)		ADDRESS OF REGISTRAR (To be filled in by registrar)	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02402

02350

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN Ib <u>30 Yrs.</u>		d. STREET ADDRESS <u>219 Mill St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>219 Mill St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Estella</u> Middle <u>Mary</u> Last <u>Bond</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>3</u> Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 1, 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Marion, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Kiser</u>		14. MOTHER'S MAIDEN NAME <u>Florence Deitrich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Howard Rudisill</u>		Address <u>221 Mill St. Hagerstown, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crowning Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>arterio-sclerotic Heart Disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-1-62</u> to <u>2-3-62</u> , that (I) (we) last saw the deceased alive on <u>3-1-62</u> , and that death occurred on <u>6-3-62</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. E. W. Jitto Jr.</u>		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. E. W. Jitto Jr.</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VR A15 (4)  
15M 7/61

05-30

05-30

M

Washington

Washington

Washington

Washington

21 Dec

Washington

21 Dec

21 Dec

62

3

January

1947

1947

1947

62

January 1, 1947

January 1, 1947

1947

January 1, 1947

January 1, 1947

January 1, 1947

January 1, 1947

January 1, 1947

January 1, 1947

None

None

*[Faint handwritten notes and signatures]*

1947

*[Faint handwritten notes and signatures]*

*[Faint handwritten notes and signatures]*

1947

1947

1947

1947

1947

1947

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02403  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02391  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>436 W. Washington St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EARL LEALAND BREWER</b>				4. DATE OF DEATH Month Day Year <b>Feby 17 1962 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 24 1882 79</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob A. Brewer</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Eyerly</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-- 219-20-2108</b>		17. INFORMANT <b>Le Roy E. Brewer 1014 Potomac Ave</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with failure</b> 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Bundle branch block</b> DUE TO (c) <b>generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>yrs</b> <b>yrs</b> <b>yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <b>Advanced senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>None</b> 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1961</b> to <b>Feb. 17, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 17, 1962</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Harold R. Tritch, Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-19-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold R. Tritch, Jr., MD</b>				22d. ADDRESS <b>302 N. Potomac Street-Hag., Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/20/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetary</b>		23d. LOCATION (City, town or county) (State) <b>Clearspring Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 21 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

VR A15 (4)  
15M 9/60



05331

05303

(M)

(1)

RECEIVED

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953

NOV 11 1953



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02404

02332

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> <b>5 MONTHS</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>960 G MAIN AVENUE</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> <b>WASHINGTON</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>960 G MAIN AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>CLOTILDA ANN BUMBAUGH</b> First Middle Last <b>4. DATE OF DEATH</b> <b>FEBRUARY 18 19 62</b> Month Day Year				<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>NOVEMBER 16 1883</b> <b>9. AGE</b> (In years last birthday) <b>78 yrs.</b> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>LITTLESTOWN PENNA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>AUGUSTUS LONG</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>MARY RIDER</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>NONE</b> <b>17. INFORMANT</b> <b>LOIS M BUMBAUGH HAGERSTOWN MARYLAND</b> Address				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis heart disease</b> 420.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cystitis</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>June 1, 1958</b> , to <b>Feb 18, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 18, 1962</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <b>Paul Harrison</b> M.D. <b>22b. DATE SIGNED</b> <b>2/20/62</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>PAUL HARRISON M. D.</b> <b>22d. ADDRESS</b> <b>318 N. POTOMAC ST. HAGERSTOWN MARYLAND</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>2-22-62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL CEMETERY</b> <b>23d. LOCATION (City, town or county)</b> <b>HAGERSTOWN MARYLAND</b> (State)				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles M. Suter</b> ADDRESS <b>SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</b> <b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 26 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Clifford S. Hanna</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

56537

CENTRAL OF DEATH

10130

11

WASH DC

NEW YORK

WASHINGTON

PAID 10/17/18

2 LINES

PAID 10/17/18

300 2 PAID 10/17/18

300 2 PAID 10/17/18

2

18

10/17/18

10/17/18

10/17/18

10/17/18

18

10/17/18

10/17/18

10/17/18

10/17/18

~~10/17/18~~

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

10/17/18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
02405 02893  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>664 N. Prospect St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Erwin</b> Last <b>Burger</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1887</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b>	IF UNDER 24 HRS. Hours <b>74</b> Min. <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furn. Mfg. &amp; Aircraft</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Smithsburg, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Jacob Burger</b>	
14. MOTHER'S MAIDEN NAME <b>Susan Popper</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>217-10-3304</b>		17. INFORMANT <b>Mrs. C. E. Burger</b> Address <b>664 N. Prospect St. Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cor pulmonale (rt sided failure)</b> DUE TO <b>emphysema &amp; arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>527.1</b> (c) <b>year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>emphysema, bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>year</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>year</b>		20f. (City or town) (County) (State) <b>year</b>	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard N. Weeks, M. D.</b>		22b. DATE SIGNED <b>2/12/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M. D.</b>		22d. ADDRESS <b>136 N. Potomac Street</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Wm. A. Weeks



20130

CERTIFICATE OF DEATH

Washington

Washington

Life

Washington

Washington County Hospital

and N. Hospital

Charles

Charles

Charles

Charles

Charles

July 22, 1887

July 22, 1887

July 22, 1887

Washington County Hospital

Washington County Hospital

Good Surge

Good Surge

217-10-3104

217-10-3104

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

Good

2/13/82

Good House Cemetery

Washington

Good House Cemetery

Washington

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02394									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				
c. LENGTH OF STAY IN b <b>22 yrs.</b>					d. STREET ADDRESS <b>Hagerstown R.D. #5</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hagerstown R.D. #5</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>John Frederick Cantner</b>					4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1962</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 17, 1914</b>		9. AGE (In years last birthday) <b>48</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frick Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Albert Cantner</b>					14. MOTHER'S MAIDEN NAME <b>Florence Saunders</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>Mrs. John F. Cantner</b>				
					17. INFORMANT <b>Hagerstown #5, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound Of Chest</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted wound of chest.</b>				
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>Noon</b> p.m. <b>2-23-</b> 19 <b>62</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>					20f. (City or town) (County) (State) <b>Route 5 Hagerstown, Washington, Md.</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>H. E. W. Ditto, Jr.</b>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>2-24-62</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>2/27/62</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Ringgold</b>					22d. LOCATION (City, town, or country) (State) <b>Hagerstown #5 Md.</b>				
23. FUNERAL DIRECTOR <b>Walter J. Moore</b>					24a. REC'D BY REGISTRAR <b>Waynesboro, Penna.</b>				
					24b. REGISTRAR'S SIGNATURE <b>DATE FEB 27 '62</b>				

M

Washington

Pennington

Washington

James H. Hargrave

ES 1000

James Hargrave

Washington, D.C.

Washington, D.C.

John

Evans

Deming

100

28

100

Info

Unit

100

Jan. 17, 1911

100

100

John

100

100

U.S.

Albert G. Hargrave

Violence Hargrave

100

100

100

100

100

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

G2407

02395

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN lb <b>FEW MINUTES</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING, MD.</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VERNIE GRACE CARBAUGH</b>		4. DATE OF DEATH Month Day Year <b>FEB. 24 19 62</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 10, 1898</b>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME DUTIES</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME DUTIES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN H. CARBAUGH</b>		14. MOTHER'S MAIDEN NAME <b>IDA MAY CLOPPER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-40-4700</b>	
17. INFORMANT <b>MRS OLIVE HULL</b>		Address <b>CLEAR SPRING, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours.</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 21, 19 62</b> to <b>Feb 24, 19 62</b> that (I) (we) last saw the deceased alive on <b>February 24, 19 62</b> and that death occurred at <b>10:10 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i> 22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		22b. DATE SIGNED <b>02/26/62</b>	
22d. ADDRESS <b>Clear Spring, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/27/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BLAIRS VALLEY CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BLAIRS VALLEY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Margaret Rowland</i> 24b. ADDRESS <b>CLEAR SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 28 '62</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

M

02307

02330

CERTIFICATE OF DEATH

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON CO. HOSPITAL

HOME

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

HOME

HOME

WASHINGTON CO. HOSPITAL

U.S.A.

DEATH CERTIFICATE

DEATH CERTIFICATE

HOME

WASHINGTON CO. HOSPITAL

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 02408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02396

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 7 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9 Marbern Road				d. STREET ADDRESS 1 925 Hamilton Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Milton Last Christner				4. DATE OF DEATH Month Feb. 14, 19 62 Day Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1892	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance				10b. KIND OF BUSINESS OR INDUSTRY West. Union Tele. Garrett, Penna.			
11. BIRTHPLACE (State or foreign country) Penna.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Austin G. Christner				14. MOTHER'S MAIDEN NAME Lydia Burkholder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 233-01-2296			
17. INFORMANT Mrs Kathleen Christner, Hag., Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-1 Coronary Occlusion DUE TO (b) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Nodular hyperplasia prostate, Diverticular sigmoid colon 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward W. Ditto III M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Edward W. Ditto III, M. D. Acting DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/16/62 Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Feb. 19, 1962		22c. NAME OF CEMETERY OR CREMATORY Halcyon Hills Mem.		22d. LOCATION (City, town, or country) (State) Wheeling, W.Va.	
23. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE FEB 19 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

NO. 100  
100-100



100-100

100-100

100-100

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
02409  
CERTIFICATE OF DEATH

02397

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Smithsburg	
f. NAME OF DECEASED (Type or print) Amanda First Middle Last Cline		g. DATE OF DEATH Month Day Year Feb. 14, 19 62	
h. SEX female	i. COLOR OR RACE white	j. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	k. DATE OF BIRTH Aug. 20, 1878
l. AGE (In years last birthday) 83		m. IF UNDER 1 YEAR Months Days Hours Min.	
n. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		o. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Frederick Co., Md.	
p. FATHER'S NAME Sam Frey		q. MOTHER'S MAIDEN NAME Sophia Kuhn	
r. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		s. SOCIAL SECURITY NO. none	
t. INFORMANT Hubert Cline, RFD 1, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4 50.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 Wks. 10 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15, 1957, to 2/14, 1962 that (I) (we) last saw the deceased alive on 2/14, 1962, and that death occurred at 1:40 AM, from the causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess M.D.		22b. DATE SIGNED 2/15/62	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		22d. ADDRESS Smithsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-17-62	
23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Church		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR DATE FEB 19 '62	
25b. REGISTRAR'S SIGNATURE			

81

I

0

1

2

0533

CERTIFICATE OF DEATH

0533



10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02410

02398

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X YARROWSBURG</b> d. STREET ADDRESS <b>1 KINGXVILLE MD. 17.1</b>	
3. NAME OF DECEASED (Type or print) <b>Helen Elizabeth COBLENTZ</b>		4. DATE OF DEATH Last <b>2</b> Month <b>11</b> Day <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 15, 1910</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BRUNSWICK FORD CO. MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOSEPH NOSE</b>	
14. MOTHER'S MAIDEN NAME <b>EMMA DANNER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>GEORGE A. COBLENTZ</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary atherosclerosis</b> (c) <b>Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Hour <b>19</b> e.m. <b>19</b> p.m.	
21. I certify that (I) (this hospital) attended the deceased from <b>January 30, 1962</b> to <b>Feb. 11, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb. 11, 1962</b> and that death occurred at <b>4:10 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Young E. Chun</b> M.D. 22b. DATE SIGNED <b>Feb. 11, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN</b>		22d. ADDRESS <b>1500 Penna. Ave Hagerstown, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 14, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BROWNSVILLE HTS. CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BROWNSVILLE WASH. CO. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Bast</b>		25a. REC'D BY REGISTRAR <b>Boonsboro MD</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>		DATE <b>FEB 16 '62</b>	



05338

05338

Helen E. Clark

COPIES

2 11 42

1942

Academy of Natural Sciences

Philadelphia, Pa.

Letter to

January 15, 1942

Dr. E. H. Rieu

Dr.

1942

For information of the Academy of Natural Sciences

Philadelphia, Pa.

Very respectfully,

Helen E. Clark

1  
TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02411

CERTIFICATE OF DEATH

02399

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>12 Hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>851 Penna Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>HOWARD WILLIAM CRAMER</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>12</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 18 1891</b>		9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS: Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept Supt. M.P. Moller Co Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown Wash Co Md.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>William F. Cramer</b>		
14. MOTHER'S MAIDEN NAME <b>Rebecca Semler</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214-09-1122</b>			17. INFORMANT <b>Mrs M. Ruth Cramer</b> Address <b>851 Penna Ave Hagerstown Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Venous thrombosis iliac vein right</b> DUE TO (c) <b>2 weeks</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>1962</b>		20g. (County) <b>Washington</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 30, 1962</b> to <b>Feb. 12, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 12, 1962</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>B. B. Kneisley</b> M.D.			22b. DATE SIGNED <b>2/13/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>			22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/15/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
23d. LOCATION (City, town or county) <b>Hagerstown Wash Co Md.</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>			24b. ADDRESS <b>Hagerstown Md.</b>		
25a. REC'D BY REGISTRAR <b>FEB 16 '62</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>		

VR A15 (4)  
15M 9/60

02333

02311

M

1

Andrew K. Collins, Nassau, N.Y.

Serial 847-42

Page 1

Continued from Page 1

Page 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02412

02100

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>20 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>320 W. HOWARD ST.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>1 320 W. HOWARD ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IDA LEE CRIM</b> First Middle Last		4. DATE OF DEATH <b>FEBRUARY 17 1962</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/5/1879</b>
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		13. FATHER'S NAME <b>RUFUS SMITH CRIM</b>	
14. MOTHER'S MAIDEN NAME <b>SARAH C. MULL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. JOHN UNGER</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Adeno Carcinoma of the Lung 1959</b> <b>Adeno Carcinoma of the Breast 1960</b> <b>770 metastasis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 7, 1959</b> , to <b>Feb 17, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 17, 1962</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert P. Conrad</b> M.D.		22b. DATE SIGNED <b>2-18-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad, M.D.</b>		22d. ADDRESS <b>137 W. Washington St Hagerstown 17</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/19/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BAKERSVILLE CHURCH CEM.</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

05150

05150

M

05150

05150

05150

05150

05150

05150

05150

05150

05150

05150

05150

05150

05150

05150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

X

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02413					02401				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Washington					a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					b. COUNTY Washington				
c. LENGTH OF STAY in lb 62 years					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 508 Summit Ave					d. STREET ADDRESS 508 Summit Ave				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Charles William De Lauder					Month Day Year February 7 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1870		9. AGE (In years last birthday) 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Organ		11. BIRTHPLACE (County & State, or foreign country) Myersville, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John H. De Lauder					14. MOTHER'S MAIDEN NAME Rebecca Renner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO. 220-10-3537				
17. INFORMANT Miss Ethel B. De Lauder					Address Hag. Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2-3 years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan. 22, 1962, to Feb. 7, 1962, that (I) (we) last saw the deceased alive on Feb. 5, 1962, and that death occurred at 12:40 P.M., from the causes and on the date stated above.									
22a. SIGNATURE B. B. Kneisley					22b. DATE Feb. 8, 1962				
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.					22d. ADDRESS 148 West Washington Street Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-10-62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown, Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

6152

212

• 1998

TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02414					02402						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY <b>WASHINGTON</b>					a. STATE <b>MARYLAND</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>					b. COUNTY <b>WASHINGTON</b>						
c. LENGTH OF STAY IN lb <b>14 DAYS</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL ROUTE #2 HAGERSTOWN</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					d. STREET ADDRESS <b>1</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			<b>LESLIE MONTAGUE DICK</b>			<b>FEBRUARY 4 19 62</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 15, 1905</b>		9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FREDERICK COUNTY VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>THOMAS JEFFERSON DICK</b>				14. MOTHER'S MAIDEN NAME <b>ALICE SHIRLEY</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <b>YES WW II</b>				16. SOCIAL SECURITY NO. <b>236-01-9209</b>		17. INFORMANT <b>MRS. LESLIE M DICK ROUTE 2 HAGERSTOWN MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: <b>578X</b> DUE TO <b>acute peritonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Rupture of transverse colon.</b>										<b>3-4 days</b> <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>Arteriosclerotic heart disease - coronary artery</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (State nature of injury, location, and Part I or Part II of the cause of death) <b>car accident</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4 Feb-62</b> to <b>4 Feb-62</b> , that (I) (we) last saw the deceased alive on <b>4 Feb-62</b> and that death occurred at <b>6:15 P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>R. T. Binford</b>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T BINFORD M. D.</b>				22d. ADDRESS <b>1135 POTOMAC AVE. HAGERSTOWN MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2-7-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENWAY CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BERKELEY SPRINGS WEST VIRGINIA</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 14 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

(M)

Agents of Insurance Co.  
Agents of Insurance Co.

3-4-40  
4-4-40

Commissioner of Insurance  
Commissioner of Insurance

29 Aug 1940  
29 Aug 1940

4 Feb 40  
R. T. Gifford

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02415

02403

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>5 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Co. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Clearspring, R#1</b> d. STREET ADDRESS <b>Western Pike</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Milton Berry Doub</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>8,</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan, 26, 1888</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel W Doub</b>		14. MOTHER'S MAIDEN NAME <b>Elton Berry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-34-0875</b>	
17. INFORMANT <b>Mrs June Doub Clearspring, Md. R#1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion with myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertensive arteriosclerotic heart disease</b> DUE TO <b>none</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Jan 20 19 62</b> <b>Feb 08 19 62</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3:35 AM</b> to <b>19 62</b> , that (I) (we) last saw the deceased alive on <b>February 08 19 62</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Archie Robert Cohen, M.D.</b>		22b. DATE SIGNED <b>Feb 09, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		22d. ADDRESS <b>Clear Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 11, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harper Cemetery</b>		23d. LOCATION (City, town or county) <b>Harper Ferry W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>13 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Archie R. Cohen</b>			

02103

M

1

*[Signature]*

Andrew J. Colman, Bakerstown, Pennsylvania



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02416

02404

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural</u> <u>Downsville</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Woburn Manor Boarding Home</u>				d. STREET ADDRESS <u>551 W. Howard St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Luther</u> Last <u>Eckstine</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1875</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Eckstine</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Virginia Startzman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>W.D. Cutchall 1847 Virginia Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Ac. MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/25/62</u> to <u>2/25/62</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2/25/62</u> , 19 <u>62</u> , and that death occurred at <u>7:00</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Young</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/27/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young M.D.</u>				22d. ADDRESS <u>101 E. Potomac St. Williamsport, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/27/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> <u>Wm. G. Horst</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02417

02405

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LETTIE</b> Middle <b>GEARHART</b> Last <b>GEARHART</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>6</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>10/8/1902</b>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Director of Arts &amp; Crafts, Volunteer worker</b>				9b. BIRTHPLACE (State or foreign country) <b>Washington County</b>		9c. AGE (In years lost birthday) yrs. <b>59</b>	
10a. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Edward J. Gearhart</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret Musselman</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Mrs. George Kunz, Fahrney-Keedy Home</b>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic PNEUMONIA</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, Rectosigmoidum, in Metastasis</b> DUE TO (c) <b>UNKNOWN</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lymphosarcoma left iliac external vein and lungs</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-8</b> , 19 <b>62</b> , to <b>FEB 6</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>FEB 6</b> , 19 <b>62</b> , and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above.				22. ADDRESS (Street, city or town, state) <b>Waynesboro, Md.</b> DATE SIGNED <b>2-7-62</b>			
ACTUAL SIGNATURE <b>E. R. LADHIZABAL</b> M.D.				PHYSICIAN'S NAME (Type) <b>E. R. LADHIZABAL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/8/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nathaniel J. Green</b>				24a. REC'D BY REGISTRAR <b>DATE 1-3 '62</b>			
ADDRESS <b>Waynesboro, Pa.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02418 CERTIFICATE OF DEATH 024108														
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State Hospital</b>					d. STREET ADDRESS <b>205 E. Franklin St.</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Catherine</b> Last <b>Geyer</b>					4. DATE OF DEATH Month <b>Feb.</b> Day <b>27</b> Year <b>1962</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.						
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housesife</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Franklin Co., Penna.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Stephen McFerren</b>					14. MOTHER'S MAIDEN NAME <b>Missouri Welsh</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>Miss Ethel Geyer</b>					17. INFORMANT <b>Hagerstown, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL THROMBOSIS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>1 YEAR</b> <b>UNKNOWN</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS -</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					(County)					(State)				
21. I certify that (1) (this hospital) attended the deceased from <b>MARCH 28, 1961</b> , to <b>FEB. 27, 1962</b> , that (1) (the) last saw the deceased alive on <b>FEB. 27, 1962</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>Antonio U. Pallacrosti</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLACROSTI</b>					22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>3/1/62</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Quincy</b>				
										23d. LOCATION (City, town or county) (State) <b>Franklin Co. Penna.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter G. Gure</b>					ADDRESS <b>Waynesboro, Penna.</b>					25a. REC'D BY REGISTRAR <b>MAR 1 '62</b>				
										25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>				





02418

Washington

Hagerstown

1 37.

Hagerstown

Western Maryland State Hospital

303 E. Franklin St.

x

Totals White

x

Sept. 12, 1933

75

Housewife

Franklin Co., Tenn.

W.A.A.

Stephen Johnson

Miss Anna Guyer

Hagerstown, Md.

Hagerstown, Tenn.

Franklin Co., Tenn.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02419

02407

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN lb <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		d. STREET ADDRESS <u>106 S. Artizan Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 S Artizan Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Annie Broadus Glascoe</u>				<b>4. DATE OF DEATH</b> <u>Feb. 14 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>NOT KNOWN</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Luray Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Andrew Broadus</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Sowers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Jackey Broadus Princess Anne</u>		Address <u>Maryland</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. myocardial infarction</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/14/62</u> to <u>2/14/62</u> , that (I) (we) last saw the deceased alive on <u>2/14/62</u> , and that death occurred at <u>3P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Calhoun Young</u>				22b. DATE SIGNED <u>2/15/62</u>		22c. PHYSICIAN'S NAME (Type) <u>Calhoun Young</u>	
22d. ADDRESS <u>Williamsport, Md.</u>				22e. REC'D BY REGISTRAR <u>Arthur L. House</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 17-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. House</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 19 '62</u>			

US407

CERTIFICATE OF DEATH

02119

M

Washington

Washington

Washington

Washington

30 yrs.

Washington

100 S. Appleton Street

100 S. Appleton Street

Washington

Washington

Washington

U.S.A.

U.S.A.

Home

Home

LOCAL POWERS

LOCAL POWERS

LOCAL POWERS

Washington

Washington

Washington

Washington

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

Washington

Washington

Washington

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02420

02408

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>11 MOS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>1 415 GUILFORD AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MILDRED</b>		First <b>GAYNELL</b> Middle <b>GOETZ</b> Last		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12</b> Year <b>19 62</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>10/26/1903</b>		9. AGE (In years last birthday) <b>58</b> rs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HARRY C. SRINGER</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE PITSNOGLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-16-4007</b>		17. INFORMANT <b>MR. WILLIAM P. GOETZ</b> Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>with Generalized Metastasis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>2 mo.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>11-25, 1958</b> to <b>2-12, 1962</b> that (I) (we) last saw the deceased alive on <b>2-12, 1962</b> and that death occurred at <b>2:30</b> PM, from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE <b>Charles F. Hess</b>		M.D.		22b. DATE SIGNED <b>2-14-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>Smithsburg Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/15/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM</b>			
23d. LOCATION (City, town or county) <b>HAGERSTOWN</b>		(State) <b>MD.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>W. F. Harment</b> ADDRESS <b>Hagerstown Md.</b>			
25a. REC'D BY REGISTRAR <b>FEB 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>					

02103

02103

M

HICESTON

11 1951

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1111 GILLING ST.

1  
M  
X  
I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
02421						02409							
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>360 Nottingham Road</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>418 Mitchell St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY MAGDADALENE GOWER</b>						4. DATE OF DEATH <b>Feb 23 1962</b> 19							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md. Eakles Cross Rd Wash Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>John Montgomery</b>						14. MOTHER'S MAIDEN NAME <b>Nannie Wade</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>214-09-4416</b>						17. INFORMANT <b>Harry H. Gower</b> Address <b>418 Mitchell St Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>42 8.0</b> IMMEDIATE CAUSE (e) <b>Venous thrombosis</b> DUE TO <b>Arteriosclerotic Heart disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 9, 1957</b> to <b>Feb 21, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 21, 1962</b> , and that death occurred at <b>12 Noon</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Paul Harrison</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/23/62</b>					
22c. PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>						22d. ADDRESS <b>318 N. Potomac St., Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/25/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Clifford L. Harris</b>					

02103

02103



RECEIVED

NOV 11 1963

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 11/11/63

TIME: 10:00 AM

BY: [Illegible]

FOR: [Illegible]

THRU: [Illegible]

INFO: [Illegible]

ATTN: [Illegible]

FILE: [Illegible]

NOTES: [Illegible]

ADMINISTRATIVE: [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02422

02410

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>	
c. LENGTH OF STAY IN 1b <u>11 yrs.</u>		d. STREET ADDRESS <u>Sharpsburg RFD #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sharpsburg HFD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Daniel</u> Last <u>Gray</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>1</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Dec. 15 1908</u>
<b>9. AGE</b> (In years last birthday) <u>53</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Installer</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Walter Gray</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mammie Kretzer</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-10-3640</u>	
<b>17. INFORMANT</b> <u>Mrs. Nellie Gray Sharpsburg Md RFD #1</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Artherosclerotic cardio-vascular disease</u> (a), stating the underlying cause last. } DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>post mortem</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>none</u> <b>19</b> <u>to</u> <u>post mortem</u> <b>that (I) (we) last saw the deceased alive on</b> <u>19</u> <b>and that death occurred at</b> <u>M.</u> <b>from the causes listed on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>Walter H. Shealy</u> M.D.		<b>22b. DATE SIGNED</b> <u>Feb. 4, 1962</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Walter H. Shealy M.D.</u>		<b>22d. ADDRESS</b> <u>Sharpsburg, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 5-62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. View Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Sharpsburg Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Alfred L. Leaf Willhomsport, Md</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 7 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Kline</u>			

14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02411

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN yrs. 35 years	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital		e. STREET ADDRESS 113 N. Locust St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen Elizabeth HADEN		4. DATE OF DEATH 2 - 9 - 1962		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1902	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (County & State, or foreign country) Lynchburg, Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Cornelious B. Tyree		14. MOTHER'S MAIDEN NAME Ada Sprouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 214-14-6368		17. INFORMANT William E. Haden	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal carcinomatosis DUE TO (b) Carcinoma of breast, Left DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1961, to Feb. 9, 1962, that (I) last saw the deceased alive on Feb. 9, 1962 and that death occurred at 8:10 M. from the causes and on the date stated above. 22a. SIGNATURE Young E. Chun M.D. 22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 1500 Penna. Ave Hagerstown, Md. 22b. DATE SIGNED Feb. 10, 1962 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-12-62 23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Gardens 23d. LOCATION (City, town or county) (State) Hagerstown, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown, Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE FEB 13 '62					

M

1

11150

CERTIFICATE OF DEATH

Washington

Bar land

Washington

Washington

7 years

in error

111 - 10000 St.

in error - 10000 St.

John E. Haden

2 - 1 - 62

1902

white

Lynchburg, Va.

John Haden

Housewife

111 - 10000 St.

111 - 10000 St.

111 - 10000 St.

111 - 10000 St.

111 - 10000 St.

111

111 - 10000 St.

John E. Haden

111 - 10000 St.

111 - 10000 St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02424

## CERTIFICATE OF DEATH

02412

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> f. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>22 MAIN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SPENCER THOMAS HALL</b>		4. DATE OF DEATH <b>FEBRUARY 1 19 62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 18, 1893</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY HALL</b>		14. MOTHER'S MAIDEN NAME <b>KATHLEEN DUNN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>056-10-3982A</b>	
17. INFORMANT <b>MRS. FLORENCE E HALL</b>		<b>253 KETCHUM ROAD MILLFORD NEW JERSEY</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic with decompensation</b> DUE TO (b) <b>coronary thrombosis</b> DUE TO (c) <b>5 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 30, 1962</b> to <b>Feb 1, 1962</b> , that (I) (we) last saw the deceased alive on <b>January 31, 1962</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G. W. LeVan</b>		22b. DATE SIGNED <b>2/1/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerald W LeVan M. D.</b>		22d. ADDRESS <b>Boonsboro Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>2-3-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GARDEN STATE CREMATORY</b>		23d. LOCATION (City, town or county) (State) <b>NORTH BERGEN NEW JERSEY</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stephen Lyons Jr</b>		25a. REC'D BY REGISTRAR <b>FEB 7 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinnard</b>		25c. ADDRESS <b>LYON'S FUNERAL HOME WESTWOOD NEW JERSEY</b>	

05115

05115

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

05

05

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

05

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>1</div> <div>02425</div> <div>02413</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Washington MARYLAND</div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Hagerstown Md.</div> <div>c. LENGTH OF STAY IN 1b</div> <div>7 1/2 Hrs.</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Washington County Hospital</div>											
<div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Washington</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>X Hancock Maryland</div> <div>d. STREET ADDRESS</div> <div>N. Penna.</div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>3. NAME OF DECEASED (Type or print)</div> <div>First Middle Last</div> <div>Lafayette Herbaugh Jr</div> <div>4. DATE OF DEATH</div> <div>Month Day Year</div> <div>2 19 1962</div>											
<div>5. SEX</div> <div>M</div> <div>6. COLOR OR RACE</div> <div>W</div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>4.6.1926</div> <div>9. AGE (In years last birthday)</div> <div>35 yrs.</div> <div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Store Manager</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Clothing</div> <div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> <div>Moorefield W.VA.</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>											
<div>13. FATHER'S NAME</div> <div>Lafayette Herbaugh Sr.</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Maude Foltz</div>											
<div>15. WAS DECEASED EVER IN U.S. ARMED SERVICE? (Yes, no, or unknown) (If yes give war or date of service)</div> <div>Yes 11</div> <div>16. SOCIAL SECURITY NO.</div> <div>235.32.6428</div> <div>17. INFORMANT</div> <div>Mrs Nita K Herbaugh Hancock Md.</div> <div>Address</div>											
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Myocardial infarction</div> <div>420.1</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div>(b) Coronary occlusions old and recent</div> <div>(c) Coronary atherosclerosis</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>12 hours</div> <div>years</div>											
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>											
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>											
<div>21. I certify that (I) (this hospital) attended the deceased from... Feb 19, 1961, to... Feb 19, 1962, that (I) (we) last saw the deceased alive on... Feb 19, 1962, and that death occurred at 11 A.M. from the causes and on the date stated above.</div>											
<div>22a. SIGNATURE</div> <div>John C. Stauffer</div> <div>22b. DATE SIGNED</div> <div>Feb 19, 1962</div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>John C Stauffer 145 S. Prospect St. Hagerstown Md.</div> <div>22d. ADDRESS</div> <div>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div>											
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> <div>23b. DATE THEREOF</div> <div>2.21.62</div> <div>23c. NAME OF CEMETERY OR</div> <div>Rest Haven</div> <div>23d. LOCATION (City, town or county)</div> <div>Hagerstown Washington Md.</div> <div>(State)</div>											
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>ADDRESS</div> <div>25a. REC'D BY REGISTRAR</div> <div>DATE FEB 23 '62</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. House</div>											

VR A15 (4)  
15M 9/60

02113

02125

Washington

Washington

Washington, D.C.

Washington, D.C.

Washington County Hospital

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02426

## CERTIFICATE OF DEATH

02414

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>310 N. Prospect St.</u>		d. STREET ADDRESS <u>310 N. Prospect St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Dewey</u> Middle <u>Sly</u> Last <u>High</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1898</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania R.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Martinsburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abram Karam High</u>		14. MOTHER'S MAIDEN NAME <u>Anna Franklin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-09-9401</u>	
17. INFORMANT <u>Mrs. Doris Spoonire</u>		Address <u>Hagerstown, Md.</u> <u>941-B Lanvale St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bronchial Asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u>  </u> , to <u>1962</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>61</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard N. Weeks, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M. D.</u>		22d. ADDRESS <u>136 N. Potomac Street</u>	
22b. DATE SIGNED <u>2/5/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/7/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>		ADDRESS <u>Hagerstown, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



02114

02488

CERTIFICATE OF DEATH

Washington

Montpelier

Washington

Hagerstown

17 Jan

Hagerstown

310 W. Market St.

310 W. Market St.

0000

January

1893

24

24

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

1893

Hagerstown, Md.

716-07-401 Mrs. Davis Spooner 411-1000 St.

No

*Handwritten signature*

*Handwritten signature*

1893

1893

*Handwritten signature*

1893

1893

1893

Hagerstown

Hagerstown

1893

Hagerstown

Hagerstown

Hagerstown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

81

I

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02427									
02415									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 2 weeks				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Williamsport				
4. DATE OF DEATH Month February Day 1 Year 1962					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William Franklin Horn					4. DATE OF DEATH Month February Day 1 Year 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1910		9. AGE (In years last birthday) 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store owner		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? C. Blanche Horn		13. FATHER'S NAME William H. Horn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number and date of service)		17. INFORMANT Mrs. Ethel Horn Williamsport Rt. 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 594X DUE TO (b) Gouty nephritis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Gouty nephritis		INTERVAL BETWEEN ONSET AND DEATH 2 months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hastie Ulcer									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Dec 1961, to Feb 1962, that (I) (we) last saw the deceased alive on Feb 1962, and that death occurred at 7:20 A.M. from the causes and on the date stated above.									
22a. SIGNATURE J. D. Wilson					22b. DATE SIGNED 2/2/62				
22c. PHYSICIAN'S NAME (Type) Dr. J. D. Wilson					22d. ADDRESS 135 North Potomac Street, Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 2-4-62				
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery					23d. LOCATION (City, town or county) (State) Hagerstown, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son					25a. REC'D BY REGISTRAR DATE FEB 6 '62				
25b. REGISTRAR'S SIGNATURE William L. Hanna									

(M)

2222

10811

Inspector

2 weeks

Inspector

Inspector

Inspector

William

Inspector

Inspector

Inspector

22

also

also

22

Inspector

Inspector

Inspector

William H. Horn

Inspector

Mrs. Ethel Horn

Inspector

Inspector

Inspector

Inspector

Inspector

Inspector

Inspector



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02428

CERTIFICATE OF DEATH

Reg. Dist. 02416

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dargan</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>Shinham Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JESSE</u> Middle <u>HERMAN</u> Last <u>HOUSER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flagman (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Train Crew</u>	
11. BIRTHPLACE (State or foreign country) <u>Engle, West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Tilghman Houser</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jane Hanes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>705-14-0584</u>	
17. INFORMANT <u>Mrs. Elizabeth Houser</u>		18. RFD# <u>1, Harpers Ferry, West Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe epistaxis with shock</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Pulmonary Abscess of R U Lobe.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 hours.</u> <u>5 Yrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema and Benign Prostatic hypertrophy.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19____, to <u>2/27/62</u> , 19____, that I last saw the deceased alive on <u>2/27/62</u> , 19____, and that death occurred at <u>3:10P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Walter H. Shealy</u> M.D. <u>Sharpsburg, Md. March 1, 1962</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Samples Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald E. Eakles</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

<div>1</div> <div>02429</div> <div>02417</div>									
<div>3</div> <div>0</div>									
<div>4</div> <div>0</div>									
<div>5</div> <div>0</div>									
<div>6</div> <div>0</div>									
<div>7</div> <div>0</div>									
<div>8</div> <div>0</div>									
<div>9</div> <div>0</div>									
<div>10</div> <div>0</div>									
<div>11</div> <div>0</div>									
<div>12</div> <div>0</div>									
<div>13</div> <div>0</div>									
<div>14</div> <div>0</div>									
<div>15</div> <div>0</div>									
<div>16</div> <div>0</div>									
<div>17</div> <div>0</div>									
<div>18</div> <div>0</div>									
<div>19</div> <div>0</div>									
<div>20</div> <div>0</div>									
<div>21</div> <div>0</div>									
<div>22</div> <div>0</div>									
<div>23</div> <div>0</div>									
<div>24</div> <div>0</div>									
1. PLACE OF DEATH a. COUNTY <u>Wash.</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>					c. LENGTH OF STAY IN 1b <u>—</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gateway Nursing Home</u>					d. STREET ADDRESS <u>Rouzererville, Pa.</u> <u>75X-3</u>				
3. NAME OF DECEASED (Type or print) <u>HARRY E. IZER</u>					4. DATE OF DEATH <u>Feb. 27, 1962</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/19/1880</u>		9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Farm</u>					11. PLACE OF BIRTH (County & State, or foreign country) <u>Franklin Co. Pa.</u>				
13. FATHER'S NAME <u>Geo. B. Izer</u>					14. MOTHER'S MAIDEN NAME <u>Ida Swigert</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, if on town) (If yes, give branch and dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>210-26-5318</u>				
17. INFORMANT <u>Clifford Izer</u>					Address <u>224 Westside Ave Hagerstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>4-21-4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Endocarditis</u> (a), stating the underlying cause last. } DUE TO <u>Chronic Endocarditis</u> (c) <u>Chronic Bronchial Asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3 weeks</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 30, 1961</u> to <u>Feb. 27, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 27, 1962</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>David R. Brewer</u> M.D.					22b. DATE SIGNED <u>2/28/62</u>				
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>					22d. ADDRESS <u>Clear Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL <u>B.</u> (Specify)			23b. DATE THEREOF <u>3/1/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Mennich - Greensboro, Pa.</u>					25a. REC'D BY REGISTRAR DATE <u>MAR 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

X

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02430 CERTIFICATE OF DEATH 02418											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>907 Mulberry Ave</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>907 Mulberry Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOSEPH MARSHALL JACKSON</b>						4. DATE OF DEATH Month <b>Feb</b> Day <b>11</b> Year <b>1962</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 25 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.R. Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pa. Harlansburg Mercer Co</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dr Homer Jackson</b>						14. MOTHER'S MAIDEN NAME <b>Alice Cross</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Rev Homer J. Jackson</b> Address <b>907 Mulberry Ave Hagerstown Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4 20.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardiovascular Disease 5 yrs.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1-22</b> <b>1962</b> to <b>2-11</b> <b>1962</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>2-10</b> <b>1962</b> , and that death occurred at <b>8:30</b> <b>P.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>E. F. Hess</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-12-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. F. Hess</b>						22d. ADDRESS <b>Smithsburg, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/15/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greendale Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Meadville Crawford Co Pa</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>						ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hess</b>	

VR A15 (4)  
15M 9/60



08118

08130



1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02419

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md</b> c. LENGTH OF STAY IN lb <b>60 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>W Church Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland 03</b> d. STREET ADDRESS <b>30 W Church Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Laura Bertha Jones</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>28</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 25 1899</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Middletown Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>John Lane</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Fisher</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Beatrice Davis Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis &amp; Thrombosis &amp; malnutrition</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>332 X</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/2/62</b>	
ACTUAL SIGNATURE <b>Howard N. Weeks</b> EXAMINER'S NAME (Type) <b>Howard N. Weeks, M. D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar 3 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or country) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR <b>John R Watson Jr Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>6 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

MEDICAL CERTIFICATION

05-13

AMERICAN EXAMINERS CERTIFICATE OF DEATH

05-13

1

RECEIVED



x

u

11/12/13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

<div>1</div> <div>02432</div> <div>02420</div>											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			WASHINGTON			a. STATE			MARYLAND		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			HAGERSTOWN			b. COUNTY			WASHINGTON		
c. LENGTH OF STAY IN			2 WEEKS			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			X PARK HALL RURAL		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
WASH. Co. Hospital						1 Boonsboro MD. R. 2.					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
LUTHER M. JONES								FEBRUARY 27, 1962			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MARCH 4, 1888		73 yrs.		11 Months 23 Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
FARMER				OWN FARM				NEAR BOLIVER, FRED. CO. MD. U.S.A.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
WILLIAM A. JONES						LAURA YOUNKINS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No.				218-38-1931		MRS. MARY JONES BOONSBORO MD. R. 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										1 month.	
1561 DUE TO Acute gastro-enteritis											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.										(b) Carcinoma of the liver	
										(c) ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Feb. 7, 1962 to Feb. 27, 1962 that (I) (we) last saw the deceased alive on Feb. 26, 1962, and that death occurred at 1 AM from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
Walter H. Shealy M. D.						22d. ADDRESS			2/28/62.		
22c. PHYSICIAN'S NAME (Type)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
BURIAL				MARCH 2, 1962		BOONSBORO CEMETERY		BOONSBORO WASH. Co. MD			
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John H. Bast						BOONSBORO MD.		DATE MAR 5 '62		Arthur L. Krause	

2000

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02433

02421

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpers Ferry</u> 85X-3 d. STREET ADDRESS _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY in 1b <u>14 3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Victoria Peach Jones</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>27</u> Year <u>1962</u>		
<b>5. SEX</b> <u>Fe</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 29, 1890</u>	<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>James F. Cassell</u>			<b>14. MOTHER'S MARDEN NAME</b> <u>Peach Smith</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <u>Mrs. William Reed - Harpers Ferry W. VA</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Atherosclerosis</u> (c) <u>none</u> (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>① Anemia ② Viral gastroenteritis</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____	<b>20f. (City or town)</b> _____	<b>(County)</b> _____	<b>(State)</b> _____
<b>21. I certify that</b> (1) (this hospital) attended the deceased from <u>2/24</u> 19 <u>61</u> , to <u>2-26</u> 19 <u>62</u> , that (1) (we) last saw the deceased alive on <u>2-26</u> 19 <u>62</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>M.E. Byrkit</u>		<b>22b. DATE SIGNED</b> <u>2-27-62</u>	<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>M.E. Byrkit</u>		<b>22d. ADDRESS</b> <u>Williamsport Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>2/1/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>HARPER CEMETERY</u>	<b>23d. LOCATION</b> (City, town, or county) <u>HARPERS FERRY, W. VA.</u> (State) _____		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edith V. Leaf - 7 Church Williamsport Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 28 '62</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. France</u>		

18780

66250



Harper Cemetery, Harper, Iowa



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02434

02422

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN 1b <u>SIX WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>REEDER NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> <b>MARYLAND</b> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>106 ST. PAUL ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLES MELVIN KLINE</u>		<b>4. DATE OF DEATH</b> <u>FEBRUARY - 6 - 1962</u>		<b>5. SEX</b> <u>MALE</u>											
<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>NOVEMBER - 12, 1872</u>											
<b>9. AGE</b> (In years last birthday) <u>89</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td><u>2</u></td> <td><u>24</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR	Months	Days	Hours	Min.		<u>2</u>	<u>24</u>			<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>REFREE EMPLOYER ROAD DEPT.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. USA</u>	
IF UNDER 1 YEAR	Months	Days	Hours	Min.											
	<u>2</u>	<u>24</u>													
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>ISAAC KLINE</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>SUSAN MILLER</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-09-9047</u>		<b>17. INFORMANT</b> <u>MRS. PAUL L. STOFFER</u> Address <u>BOONSBORO MD.</u>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)											
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 5 1962</u> <b>to</b> <u>Feb 6 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 5 1962</u> , <b>and that death occurred at</b> <u>5 PM</u> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>G. W. Lelan</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/7/62</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>G. W. Lelan</u>		<b>22d. ADDRESS</b> <u>Boonsboro, Md.</u>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>FEBRUARY 9, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>BOONSBORO CEMETERY</u>											
<b>23d. LOCATION</b> (City, town or county) <u>BOONSBORO WASH. CO. MD.</u>		<b>23e. (State)</b>		<b>23f. (Country)</b>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John W. East</u>		<b>ADDRESS</b> <u>BOONSBORO MD.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 13 '62</u>											
<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Thomas</u>															

55180

1950



1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02435

Items 5, 13 & 14 Film G-10 4/2/62 iwk

## CERTIFICATE OF DEATH

02423

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>9 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1028 Mulberry Ave</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1 1028 Mulberry Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUTH REID LEMEN</b>		4. DATE OF DEATH <b>Feb 19 1962 19</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>June 20 1874 87 yrs.</b>	
9. AGE (In years last birthday) <b>87</b>		10. IF UNDER 1 YEAR Months Days <b>3 mos</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Waynesboro Franklin Co Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>A. William H. Reid</b>		14. MOTHER'S MAIDEN NAME <b>Emma Amelia Snively Snively</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Robert C. Porter</b>		Address <b>1028 Mulberry Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>21</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 19, 1961</b> to <b>Feb 19, 1962</b> , that (I) (we) last saw the deceased alive on <b>2/17 1962</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert V. H. Campbell</b>		22b. DATE SIGNED <b>2/21/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. H. Campbell</b>		22d. ADDRESS <b>Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/22/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

VR A15 (4)  
15M 9/60

02150

02150



1  
M  
X  
I  
0  
1  
BL  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
ISM 9/60

1  
M  
X  
I  
0  
1  
BL  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02436  
CERTIFICATE OF DEATH  
02424

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 6</b> c. LENGTH OF STAY IN lb <b>55 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cearfoss Pike</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <b>Washington</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 6</b> d. STREET ADDRESS <b>Cearfoss Pike</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLARA</b> <b>ETTA</b> <b>LONG</b>				4. DATE OF DEATH <b>Feby 3 1962</b> <b>19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 27 1870</b>	
9. AGE (In years last birthday) <b>91 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>19</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry Calvin Foltz</b>				14. MOTHER'S MAIDEN NAME <b>Annie Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>M. Kenneth Long</b> <b>Hagerstown Md. R # 6</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension Cerebral Vascular Disease</b> <b>443</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Senility</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>6-1-1958 to 3-3-62</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-1-1958</b> to <b>3-3-62</b> , that (I) (we) last saw the deceased alive on <b>3-3-62</b> , and that death occurred <b>5 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. E. W. H. T. To J</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. E. W. H. T. To J</b>				22d. ADDRESS <b>Hagerstown Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>L. P. H. H.</b>			

02421

02430

(M)

Washington

Washington

Legation

Legation

Legation

Legation

1907

1907

1907

1907

1907

1907

1907

1907

Legation

Legation

Legation

Amir

Amir

Amir

Amir

*Handwritten signature*

1907

1907

*Handwritten signature*

*Handwritten signature*

1907

1907

1907

1907



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02425

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN lb <b>10 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>922 POPE AVENUE</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>922 POPE AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MINNIE ALICE LONG</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>18</b> Year <b>1962</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARTINSBURG WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>CHARLES V MASON</b>				14. MOTHER'S MAIDEN NAME <b>MARY J FRANKS</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-34-4077</b>		17. INFORMANT <b>MRS WINIFRED SNAVELY HAGERSTOWN MARYLAND</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Chronic Vascular Disease</b> DUE TO <b>5 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Self down stairs at time of fall</b>										INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <b>6 p.m. 2-18-62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown Work Md</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>A. E. W. Ditto Jr.</b>		M.D. <b>E.W.DITTO JR. M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>E.W.DITTO JR. M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		215 W WASHINGTON ST.		DATE SIGNED <b>2-18-62</b>					
Address (Street, city, town, or county) <b>HAGERSTOWN MARYLAND</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-21-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSEDALE CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>MARTINSBURG WEST VIRGINIA</b>					
23. FUNERAL DIRECTOR <b>SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 26 '62</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. Thomas</b>					

FOR STATE  
HEALTH DEPT.



STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER CERTIFICATE OF DEATH

1. NAME OF DECEASED: *George Washington*

2. AGE: *45*

3. SEX: *Male*

4. RACE: *White*

5. OCCUPATION: *Teacher*

6. PLACE OF BIRTH: *Virginia*

7. DATE OF DEATH: *Jan 15 1902*

8. TIME OF DEATH: *10:30 AM*

9. CAUSE OF DEATH: *Heart Failure*

10. DISEASE OR INJURY: *Coronary Artery Disease*

11. SIGNATURE OF EXAMINER: *W. B. Smith*

12. SIGNATURE OF ATTENDING PHYSICIAN: *J. D. Jones*

13. SIGNATURE OF FUNERAL HOME: *John Doe*

14. SIGNATURE OF WITNESSES: *John Doe, Jane Smith*

15. SIGNATURE OF CORONER: *John Doe*

16. SIGNATURE OF JURY: *John Doe, Jane Smith*

17. SIGNATURE OF JUDGE: *John Doe*

18. SIGNATURE OF CLERK: *John Doe*

19. SIGNATURE OF SHERIFF: *John Doe*

20. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

21. SIGNATURE OF CONSTABLE: *John Doe*

22. SIGNATURE OF JAILER: *John Doe*

23. SIGNATURE OF PRISONER: *John Doe*

24. SIGNATURE OF WARDEN: *John Doe*

25. SIGNATURE OF CHIEF OF POLICE: *John Doe*

26. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

27. SIGNATURE OF SHERIFF: *John Doe*

28. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

29. SIGNATURE OF CONSTABLE: *John Doe*

30. SIGNATURE OF JAILER: *John Doe*

31. SIGNATURE OF PRISONER: *John Doe*

32. SIGNATURE OF WARDEN: *John Doe*

33. SIGNATURE OF CHIEF OF POLICE: *John Doe*

34. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

35. SIGNATURE OF SHERIFF: *John Doe*

36. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

37. SIGNATURE OF CONSTABLE: *John Doe*

38. SIGNATURE OF JAILER: *John Doe*

39. SIGNATURE OF PRISONER: *John Doe*

40. SIGNATURE OF WARDEN: *John Doe*

41. SIGNATURE OF CHIEF OF POLICE: *John Doe*

42. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

43. SIGNATURE OF SHERIFF: *John Doe*

44. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

45. SIGNATURE OF CONSTABLE: *John Doe*

46. SIGNATURE OF JAILER: *John Doe*

47. SIGNATURE OF PRISONER: *John Doe*

48. SIGNATURE OF WARDEN: *John Doe*

49. SIGNATURE OF CHIEF OF POLICE: *John Doe*

50. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

51. SIGNATURE OF SHERIFF: *John Doe*

52. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

53. SIGNATURE OF CONSTABLE: *John Doe*

54. SIGNATURE OF JAILER: *John Doe*

55. SIGNATURE OF PRISONER: *John Doe*

56. SIGNATURE OF WARDEN: *John Doe*

57. SIGNATURE OF CHIEF OF POLICE: *John Doe*

58. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

59. SIGNATURE OF SHERIFF: *John Doe*

60. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

61. SIGNATURE OF CONSTABLE: *John Doe*

62. SIGNATURE OF JAILER: *John Doe*

63. SIGNATURE OF PRISONER: *John Doe*

64. SIGNATURE OF WARDEN: *John Doe*

65. SIGNATURE OF CHIEF OF POLICE: *John Doe*

66. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

67. SIGNATURE OF SHERIFF: *John Doe*

68. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

69. SIGNATURE OF CONSTABLE: *John Doe*

70. SIGNATURE OF JAILER: *John Doe*

71. SIGNATURE OF PRISONER: *John Doe*

72. SIGNATURE OF WARDEN: *John Doe*

73. SIGNATURE OF CHIEF OF POLICE: *John Doe*

74. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

75. SIGNATURE OF SHERIFF: *John Doe*

76. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

77. SIGNATURE OF CONSTABLE: *John Doe*

78. SIGNATURE OF JAILER: *John Doe*

79. SIGNATURE OF PRISONER: *John Doe*

80. SIGNATURE OF WARDEN: *John Doe*

81. SIGNATURE OF CHIEF OF POLICE: *John Doe*

82. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

83. SIGNATURE OF SHERIFF: *John Doe*

84. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

85. SIGNATURE OF CONSTABLE: *John Doe*

86. SIGNATURE OF JAILER: *John Doe*

87. SIGNATURE OF PRISONER: *John Doe*

88. SIGNATURE OF WARDEN: *John Doe*

89. SIGNATURE OF CHIEF OF POLICE: *John Doe*

90. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

91. SIGNATURE OF SHERIFF: *John Doe*

92. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

93. SIGNATURE OF CONSTABLE: *John Doe*

94. SIGNATURE OF JAILER: *John Doe*

95. SIGNATURE OF PRISONER: *John Doe*

96. SIGNATURE OF WARDEN: *John Doe*

97. SIGNATURE OF CHIEF OF POLICE: *John Doe*

98. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

99. SIGNATURE OF SHERIFF: *John Doe*

100. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

101. SIGNATURE OF CONSTABLE: *John Doe*

102. SIGNATURE OF JAILER: *John Doe*

103. SIGNATURE OF PRISONER: *John Doe*

104. SIGNATURE OF WARDEN: *John Doe*

105. SIGNATURE OF CHIEF OF POLICE: *John Doe*

106. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

107. SIGNATURE OF SHERIFF: *John Doe*

108. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

109. SIGNATURE OF CONSTABLE: *John Doe*

110. SIGNATURE OF JAILER: *John Doe*

111. SIGNATURE OF PRISONER: *John Doe*

112. SIGNATURE OF WARDEN: *John Doe*

113. SIGNATURE OF CHIEF OF POLICE: *John Doe*

114. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

115. SIGNATURE OF SHERIFF: *John Doe*

116. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

117. SIGNATURE OF CONSTABLE: *John Doe*

118. SIGNATURE OF JAILER: *John Doe*

119. SIGNATURE OF PRISONER: *John Doe*

120. SIGNATURE OF WARDEN: *John Doe*

121. SIGNATURE OF CHIEF OF POLICE: *John Doe*

122. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

123. SIGNATURE OF SHERIFF: *John Doe*

124. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

125. SIGNATURE OF CONSTABLE: *John Doe*

126. SIGNATURE OF JAILER: *John Doe*

127. SIGNATURE OF PRISONER: *John Doe*

128. SIGNATURE OF WARDEN: *John Doe*

129. SIGNATURE OF CHIEF OF POLICE: *John Doe*

130. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

131. SIGNATURE OF SHERIFF: *John Doe*

132. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

133. SIGNATURE OF CONSTABLE: *John Doe*

134. SIGNATURE OF JAILER: *John Doe*

135. SIGNATURE OF PRISONER: *John Doe*

136. SIGNATURE OF WARDEN: *John Doe*

137. SIGNATURE OF CHIEF OF POLICE: *John Doe*

138. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

139. SIGNATURE OF SHERIFF: *John Doe*

140. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

141. SIGNATURE OF CONSTABLE: *John Doe*

142. SIGNATURE OF JAILER: *John Doe*

143. SIGNATURE OF PRISONER: *John Doe*

144. SIGNATURE OF WARDEN: *John Doe*

145. SIGNATURE OF CHIEF OF POLICE: *John Doe*

146. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

147. SIGNATURE OF SHERIFF: *John Doe*

148. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

149. SIGNATURE OF CONSTABLE: *John Doe*

150. SIGNATURE OF JAILER: *John Doe*

151. SIGNATURE OF PRISONER: *John Doe*

152. SIGNATURE OF WARDEN: *John Doe*

153. SIGNATURE OF CHIEF OF POLICE: *John Doe*

154. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

155. SIGNATURE OF SHERIFF: *John Doe*

156. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

157. SIGNATURE OF CONSTABLE: *John Doe*

158. SIGNATURE OF JAILER: *John Doe*

159. SIGNATURE OF PRISONER: *John Doe*

160. SIGNATURE OF WARDEN: *John Doe*

161. SIGNATURE OF CHIEF OF POLICE: *John Doe*

162. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

163. SIGNATURE OF SHERIFF: *John Doe*

164. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

165. SIGNATURE OF CONSTABLE: *John Doe*

166. SIGNATURE OF JAILER: *John Doe*

167. SIGNATURE OF PRISONER: *John Doe*

168. SIGNATURE OF WARDEN: *John Doe*

169. SIGNATURE OF CHIEF OF POLICE: *John Doe*

170. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

171. SIGNATURE OF SHERIFF: *John Doe*

172. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

173. SIGNATURE OF CONSTABLE: *John Doe*

174. SIGNATURE OF JAILER: *John Doe*

175. SIGNATURE OF PRISONER: *John Doe*

176. SIGNATURE OF WARDEN: *John Doe*

177. SIGNATURE OF CHIEF OF POLICE: *John Doe*

178. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

179. SIGNATURE OF SHERIFF: *John Doe*

180. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

181. SIGNATURE OF CONSTABLE: *John Doe*

182. SIGNATURE OF JAILER: *John Doe*

183. SIGNATURE OF PRISONER: *John Doe*

184. SIGNATURE OF WARDEN: *John Doe*

185. SIGNATURE OF CHIEF OF POLICE: *John Doe*

186. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

187. SIGNATURE OF SHERIFF: *John Doe*

188. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

189. SIGNATURE OF CONSTABLE: *John Doe*

190. SIGNATURE OF JAILER: *John Doe*

191. SIGNATURE OF PRISONER: *John Doe*

192. SIGNATURE OF WARDEN: *John Doe*

193. SIGNATURE OF CHIEF OF POLICE: *John Doe*

194. SIGNATURE OF DEPUTY CHIEF OF POLICE: *John Doe*

195. SIGNATURE OF SHERIFF: *John Doe*

196. SIGNATURE OF DEPUTY SHERIFF: *John Doe*

197. SIGNATURE OF CONSTABLE: *John Doe*

198. SIGNATURE OF JAILER: *John Doe*

199. SIGNATURE OF PRISONER: *John Doe*

200. SIGNATURE OF WARDEN: *John Doe*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02438

02426

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>1yr-5mo-24days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium Inc.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1118 Oak Hill Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Louise Martha Lovett</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>12</u> Year <u>1962</u>					
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept 15, 1884</u>	<b>9. AGE (In years last birthday)</b> <u>77</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Chicago, Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William Weiss</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Vollman</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>Mrs HARVEY H. HAYSER Jr HAGERSTOWN MD.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>4-20-00</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerosis - General</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 hr. -</u> <u>8 yrs.</u> <u>8 yrs. +</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
		<b>20f. (City or town)</b> <u>March 1954 to Feb. 12, 1962</u>		<b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 1954</u> <b>to</b> <u>Feb. 12, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 12, 1962</u> , <b>and that death occurred at</b> <u>7:15 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Lloyd A. Hoffman</u>		<b>22b. DATE SIGNED</b> <u>Feb. 13-62</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>LLOYD A. HOFFMAN M. D.</u>		<b>22d. ADDRESS</b> <u>214 N. POTOMAC ST. HAGERSTOWN MARYLAND</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2-14-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR LAWN MEMORIAL GARDENS HAGERSTOWN MARYLAND</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 19 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kincaid</u>			

10123

02432

(M)

(A)

MAILED 11-11-62

MAILED 11-11-62

11-11-62

11-11-62

MAILED 11-11-62

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND AND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN TB <b>1 DAY</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>PRINCE GEORGES</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLMAR MANOR</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WESTERN MD. STATE HOSPITAL</b>		d. STREET ADDRESS <b>3427 40TH PLACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY JULIA MADDOX</b>		4. DATE OF DEATH Month Day Year <b>Feb. 28 1962</b>		5. SEX <b>F</b>	
6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 23, 1876</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN MADDOX</b>		14. MOTHER'S MAIDEN NAME <b>MARY MADDOX</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>MRS. JULIA TRICK, COLMAR MANOR, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Part I A</b> <b>Arteriosclerotic cardio vascular disease</b> DUE TO <b>Part II</b> <b>Self while walking at home</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>6 mo</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self while walking at home</b>		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>9-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Colmar Manor Prince Georges Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/28/62</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
22b. DATE THEREOF <b>3-3-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL</b>		22d. LOCATION (City, town, or country) (State) <b>FRONT ROYAL VA.</b>		23. FUNERAL DIRECTOR ADDRESS <b>MADDOX FUNERAL HOME - FRONT ROYAL, VA.</b>		24a. REC'D BY REGISTRAR <b>MAR 5 '62</b>		24b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>	



FOR MAIL





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
81  
I  
0  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02440  
CERTIFICATE OF DEATH  
02428

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown Hagerstown</u> d. STREET ADDRESS <u>Wash. Co. Hospital 2078 Lincoln Ave</u> e. IS RESIDENCE ON PREMISES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy MARTIN</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/19/62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, md.</u>	
13. FATHER'S NAME <u>Harold Martin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Vivian Kendall</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harold Martin</u> Address <u>207 Lincoln Ave Hagerstown md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydn exphelus</u> <u>751.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Spine bifida</u> (a), stating the underlying cause last. DUE TO (c) <u>At election</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hr</u> <u>4 hr</u> <u>4 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/19</u> , 19 <u>62</u> , to <u>2/20</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>62</u> , and that death occurred at <u>3:24 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>E. J. Hoochler</u> M.D.		22b. DATE SIGNED <u>2/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. J. Hoochler</u>		22d. ADDRESS <u>Hagerstown Md.</u>	
23a. FUNERAL, CREMATION, or BURIAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/21/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ringgold Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Ringgold, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Mennich</u> ADDRESS <u>Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Harris</u> DATE <u>FEB 23 '62</u>	
		25b. REGISTRAR'S SIGNATURE	

85150

1958

(M)



(1)



Handwritten notes at the bottom of the page, including "Roughly 1958" and "The Thomas - Thompson Co."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02441  
CERTIFICATE OF DEATH

02429

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 Hr</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>823 1/2 Pine St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Unnamed Baby Girl</b> First Middle Last <b>Martin</b>		4. DATE OF DEATH Month Day Year <b>Feb 14 1962 19.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 14 1962</b>	
9. AGE (In years last birthday) <b>1</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert C. Martin Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Helen D. Summers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Robert C. Martin Jr.</b>		Address <b>823 1/2 Pine St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intant cause pneumonia</b> 763.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Premature rupture of membranes</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>6 days.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>14 Feb</b> , 19 <b>62</b> to <b>14 Feb</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>14 Feb</b> , 19 <b>62</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold H. Gist</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>16 Feb 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold H. Gist</b>		22d. ADDRESS <b>111 N. Potomac St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/16/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Luthern Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Leitersburg Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>FEB 20 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

2081363213

05/30

292



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02442					02430									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY		Washington			e. STATE		Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown			b. COUNTY		Allegany							
c. LENGTH OF STAY IN 1b		2 Weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Western Maryland State Hospital					317 Columbia Street									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
ARCHIE SCOTT MARVIN					FEB 28 1962									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		October 4, 1913		48 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Painting Contractor			Maryland			U. S. A.								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Scott Marvin					Laura Middleton									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
No					214-07-5222					Mrs. Ida Benzell				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					21. I certify that (I) (this hospital) attended the deceased from 2-14-1962 to 2-28-1962 that (I) (we) last saw the deceased alive on 2-28-1962 and that death occurred at 11:00 PM, from the causes and on the date stated above.					22b. DATE SIGNED				
PART I. DEATH WAS CAUSED BY:					IMMEDIATE CAUSE (a)					Lobular pneumonia, bilateral				
144X					DUE TO					carcinoma of mouth & local metastasis				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b)					1 year				
DUE TO					(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 2-14-1962 to 2-28-1962 that (I) (we) last saw the deceased alive on 2-28-1962 and that death occurred at 11:00 PM, from the causes and on the date stated above.										22a. SIGNATURE				
										Victor L. Ramos, M.D.				
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS				
Victor L. Ramos, M.D.										1500 Pa Arc Hagerstown Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORY				
Burial					3/3/62					Hillcrest Burial Park				
										23d. LOCATION (City, town or county) (State)				
										Cumberland Maryland				
24 FUNERAL DIRECTOR'S SIGNATURE					404 Decatur Street					25a. REC'D BY REGISTRAR				
Ruth E. Silcox					Cumberland Maryland					DATE MAR 5 '62				
										25b. REGISTRAR'S SIGNATURE				
										C. S. Kraus				



00150

02442





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02443

Item 23d, Film G307 2/13/62 iwk

02431

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL REP #2 Hyattsville</b> c. LENGTH OF STAY IN 1b <b>90</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GATEWAY CONVELESANT HOME</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BIG POOL</b> d. STREET ADDRESS <b>RURAL</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RACHAEL MARY MASON</b>		4. DATE OF DEATH Month Day Year <b>FEB. 4 19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME DUTIES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>	9. AGE (In years last birthday) <b>83</b> yrs. <b>4</b> Months <b>17</b> Days 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>CHARLES CHANEY</b>		14. MOTHER'S MAIDEN NAME <b>CEILIE BOWMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CLARENCE MASON</b>		Address <b>PECKTONVILLE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Arterial Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>5 yrs.</b> <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 11 1962</b> to <b>Feb 4 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 3 1962</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David R. Brewer</b>		22b. DATE SIGNED <b>2/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		22d. ADDRESS <b>Clear Spring Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/6/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARKHEAD CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>Washington County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rauland Margaret</b>		25a. REC'D BY REGISTRAR <b>FEB 8 '62</b>	
ADDRESS <b>CLEAR SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



102801

DEPARTMENT OF JUSTICE

102801

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

102801

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02444

02432

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>8 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1301 Marshall St</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1301 Marshall St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>HARVEY LEWIS MAUGANS</b>		<b>4. DATE OF DEATH</b> <b>Feb 7 19 62</b>		<b>5. SEX</b> <b>Male</b>			
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 14 1904</b>			
<b>9. AGE</b> (In years last birthday) <b>57 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Self Employed York York Co Pa.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Harvey L. Maugans Sr.</b>					
<b>14. MOTHER'S MAIDEN NAME</b> <b>Florence Slick</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>220-18-0304</b>		<b>17. INFORMANT</b> <b>Mrs N. Irene Maugans 1301 Marshall St Hagerstown Md</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>527.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Congestive Heart Failure</b> DUE TO <b>101.0</b> (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from 11-1-61, 19 to 2-7-62, that (I) (we) last saw the deceased alive on 2-4-62, 19, and that death occurred at 11 A.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Andrew K. Coffman</b> M.D.							
<b>22b. ADDRESS</b> <b>Hagerstown Md</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>							
<b>23b. DATE THEREOF</b> <b>2/10/62</b>							
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>							
<b>23d. LOCATION</b> (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman Hagerstown Md.</b>							
<b>25a. REC'D BY REGISTRAR</b> <b>FEB 13 '62</b>							
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03135

GENERAL STATE OF TEXAS

03441

(M)

State of Texas, County of \_\_\_\_\_

do hereby certify that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

is the \_\_\_\_\_ of \_\_\_\_\_

and that \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Parker

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02445

02433

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washingtn</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1 724 Medway Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Barry Edward Miller</b>				<b>4. DATE OF DEATH</b> <b>February 10 1962</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 7, 1875</b>	
<b>9. AGE</b> (In years last birthday) <b>86</b>		<b>IF UNDER 1 YEAR</b> Months <b>03</b> Days <b>03</b>		<b>IF UNDER 24 HRS.</b> Hours <b>00</b> Min. <b>00</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Hauling</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Transfer Co.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Hagerstown, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Alex Miller</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ann Proctor</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service)		<b>17. INFORMANT</b> <b>Leon Hoover Norfolk, Va.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>446 X</b> IMMEDIATE CAUSE (a) <b>uremia</b> DUE TO (b) <b>nephrosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>Ende</b> <b>Ende</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 1/16/62 to 2/10/62, that (I) (we) last saw the deceased alive on 2/10/62, and that death occurred at 9:35 P.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Robert Vh. Campbell M.D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2/12/62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Robert Vh. Campbell</b>				<b>22d. ADDRESS</b> <b>145 W Washington St. Hagerstown Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2-13-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Hagerstown, Md.</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Scott F. Minnich &amp; Son</b>				<b>ADDRESS</b> <b>Hagerstown, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>FEB 15 '62</b> <b>Arthur S. Kraus</b>	

1950

55150



4 1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02434											
1. PLACE OF DEATH e. COUNTY <b>WASHINGTON</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. LENGTH OF STAY IN 1b <b>2 HOURS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						d. STREET ADDRESS <b>941 PRESTON ROAD</b>					
3. NAME OF DECEASED (Type or print) <b>RICHARD ARTHUR MOTZ JR.</b>						4. DATE OF DEATH <b>FEBRUARY 18 19 62</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 23 1944</b>		9. AGE (In years last birthday) <b>17 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>HAGERSTOWN MARYLAND</b>		
13. FATHER'S NAME <b>RICHARD ARTHUR MOTZ SR.</b>						14. MOTHER'S MAIDEN NAME <b>JANE E HARMS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>						16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RICHARD A MOTZ SR. HAGERSTOWN MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basilar Skull fracture &amp; Brain Stem injury and Intracranial Hemorrhage</b> DUE TO (b) <b>2 hrs.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>Internal Injury</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Internal Injury</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collision with train while driving auto</b>					
20c. TIME OF INJURY Hour e.m. p.m. <b>10:30 2-17-62</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Northern Box</b>			20f. (City or town) (County) (State) <b>Hagerstown Wash. Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Schwald W. D. M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>E.W. DITTO JR. M.D.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>						22b. DATE THEREOF <b>2-20-62</b>			22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		
23. FUNERAL DIRECTOR <b>SUTER-ROUZER FUNERAL HOME</b>						22d. LOCATION (City, town, or country) (State) <b>HAGERSTOWN MARYLAND</b>			24e. REC'D BY REGISTRAR <b>FEB 26 '62</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kuno</b>						DATE <b>FEB 26 '62</b>					

2/19/62  
DATE SIGNED

MAKING ALL THE STATE OF NEW YORK  
STATISTICAL BUREAU AND RECORDS AND VITALITY SECTION  
1945 MEDICAL EXAMINER'S REPORT OF DEATH

DATE OF DEATH  
PLACE OF DEATH

11

1

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. RACE: [illegible]  
5. OCCUPATION: [illegible]  
6. PLACE OF BIRTH: [illegible]  
7. DATE OF BIRTH: [illegible]  
8. DATE OF DEATH: [illegible]  
9. PLACE OF DEATH: [illegible]  
10. CAUSE OF DEATH: [illegible]  
11. MANNER OF DEATH: [illegible]  
12. SIGNATURE OF EXAMINER: [illegible]  
13. DATE OF EXAMINATION: [illegible]

1-24-45

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02447  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02435

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1/2 Hr</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 4</b> d. STREET ADDRESS <b>Cearfoss</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDITH MERLE MYERS</b>				4. DATE OF DEATH <b>Feby 17 1962 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31 1897</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Four Locks Wash Co Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Daniel Shank</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Perrott</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Preston E. Myers</b>				Address <b>Hagerstown Md R # 4</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> <b>Certain Abusive Heart Disease</b> DUE TO (b) <b>Diabetes</b> DUE TO (c) <b>Obesity</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 3 yrs 7 mos</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-4-62</b> to <b>2-17-62</b> , that (I) (we) last saw the deceased alive on <b>2-17-62</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. E. W. A. T. J.</b>				22b. DATE SIGNED <b>2/17/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. E. W. A. T. J.</b>				22d. ADDRESS <b>Hagerstown Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/20/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Broadfording Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Andrew K. Coffman</b>			

72230.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02448

02436

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN <u>40</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>818 Concord St.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Isaiah Franklin Myers</u>				<b>4. DATE OF DEATH</b> <u>February 4 19 62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4, 1913</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Near Hagerstown, Md.</u>			
13. FATHER'S NAME <u>Isaiah Myers</u>			14. MOTHER'S MAIDEN NAME <u>Anne Hastings</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-7126</u>		17. INFORMANT <u>Mrs. Arlene L. Myers Hagerstown, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure &amp; cardiac hypertrophy</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease (?)</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/4/62</u> , to <u>2/4/62</u> , that (I) (we) last saw the deceased alive on <u>2/4/62</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard N. Weeks</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/5/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Gardens</u>			
23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>							
24 FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Robert L. Thomas</u>			

VR A15 (4)  
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02442

02442

Washington

Washington

Washington County Hospital

St. George's

Leah

Franklin

Leah

02

Leah

Leah

Leah

011 Co.

Leah

Leah

Leah

011-1111

Leah

(9)

Leah

Leah

Leah

Leah

Scott J. Minnion & Son, Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02449

02437

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>3 wks.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Co. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>405 Edgewood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CATHERINE MARY NINER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1899</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Midland, Allegany Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Stevenson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Morris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-2695</b>	
17. INFORMANT <b>Herbert E. Niner, 405 Edgewood Dr.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO (b) <b>Hypertensive arteriosclerotic cardiovascular dis.</b> DUE TO (c) <b>Congestive heart failure</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>14 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Congestive heart failure</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 28, 1962</b> to <b>Feb. 28, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 28, 1962</b> , and that death occurred at <b>5:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. C. Stauffer, M.D.</b>		22b. DATE SIGNED <b>3-1-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. C. Stauffer, M.D. / W. N. Fender</b>		22d. ADDRESS <b>145 S. Prospect St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/3/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Hagerstown, Maryland.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR <b>5 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Charles L. Hanna</b>	

2280

5350

central bank systems

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02450 CERTIFICATE OF DEATH 02438

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u>		c. LENGTH OF STAY IN 1b <u>57 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Md. RFD #1</u>		d. STREET ADDRESS <u>Williamsport Md. RFD #1</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Belle Palmer</u>		4. DATE OF DEATH <u>Feb. 7 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25 1877</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u>	
11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>12</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Haugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Frances Miller Williamsport Md RFD #1</u>		Address <u>Williamsport Md RFD #1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Diffuse carcinomatosis</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Large Bowel Carcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12</u> p.m. <u>12</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>Williamsport Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-23</u> , <u>1961</u> , to <u>2-7</u> , <u>1962</u> that (we) last saw the deceased alive on <u>1-18</u> , <u>1962</u> and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>2-8-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 10-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wiverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>		25c. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

M

02250

OFFICE OF DEATH

02250

Washington

Washington

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02451

## CERTIFICATE OF DEATH

02439

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUCTOWN</u>		c. LENGTH OF STAY in 1b <u>5</u> <u>WEEKS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL NEAR SMITHSBORO</u>		d. STREET ADDRESS <u>SMITHSBORO MD. R. 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HAGERSTOWN MD. R. 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MAUDE A. PALMER</u>				4. DATE OF DEATH <u>FEBRUARY 12, 1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 24, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BOONSBORO WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES A. GABE</u>				14. MOTHER'S MAIDEN NAME <u>LUCINDA DANNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-09-8313</u>			
17. INFORMANT <u>HARRY S. PALMER</u>				Address <u>HAGERSTOWN MD. R. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (the hospital) attended the deceased from <u>1-8</u> , 19 <u>56</u> to <u>2-12</u> , 19 <u>62</u> , that (I) (the) last saw the deceased alive on <u>6-12</u> , 19 <u>62</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>				22d. ADDRESS <u>Smithsburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 15, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City, town or county) <u>HAGERSTOWN WASH. CO. MD.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Bad</u> ADDRESS <u>BOONSBORO MD</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



03130

CERTIFICATE OF DEATH

03131



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "DEATH", "CERTIFICATE", and "MAY" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02452

02440

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>229 Alexander St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Henry</u> Last <u>Randall</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>54</u> Days <u>54</u>	IF UNDER 24 HRS. Hours <u>54</u> Min. <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry C. Randall</u>	
14. MOTHER'S MAIDEN NAME <u>Icila Deville Baker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>214-09-9793</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Miss Catherine Randall 229 Alexander St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Cirrhosis of Liver</u> DUE TO <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>1 week</u> <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 61</u> to <u>Feb 8</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Feb 8</u> , 19 <u>62</u> , and that death occurred at <u>6</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Jos C. Crisp</u> M.D.		22b. DATE SIGNED <u>2-11-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOS C. CRISP</u>		22d. ADDRESS <u>115 King St. Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/11/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 13 '62</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

M

1

02422

Washington

Washington

Washington County, Maryland

Richard Henry

White

Corporate

Henry C. Kendall

218-00-0703

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

WASHINGTON OF BEATH

Washington

Washington

Washington County, Maryland

Richard Henry

White

Corporate

Henry C. Kendall

218-00-0703

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

02422

Washington

Washington

Washington County, Maryland

Richard Henry

White

Corporate

Henry C. Kendall

218-00-0703

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02441

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 46 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 52 Fairgreen Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Sloan Reisner First Middle Last		4. DATE OF DEATH February 27 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1877 yrs. Months Days Hours Min.
9. AGE (in years by birthday) 84 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) Own Home		12. CITIZEN OF WHAT COUNTRY? McConnellsburg, Pa.	
13. FATHER'S NAME Thomas F. Sloan		14. MOTHER'S MAIDEN NAME Josephine Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT W. H. Reisner Jr.		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904 a0 Coronary Occlusion DUE TO (b) Hypertensive Cardio Vascular Disease DUE TO (c) Fracture Of Femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Instant Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Became dizzy while walking fell fracturing her hip.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10 2-26-1962		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Hagerstown, Washington, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-28-62	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1, 1962	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or country) McConnellsburg, Pa. (State)	
23. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

WINDY



US 11

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-11-11

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

22 years 10 months

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02454

02442

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>31 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>950 Kenwood Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Davidson</u> Last <u>Riley</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1907</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Shippensburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Howard Riley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Rosanna Davidson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-4941</u>		17. INFORMANT Address <u>Mrs. H.D. Riley 950 Kenwood Dr. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic retinitis due to old histoplasmosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 Days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18, 1961</u> , to <u>Feb 1, 1962</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Feb 1, 1962</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/3/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>				22d. ADDRESS <u>217 West Washington St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Horst</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 5 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4520



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02455

02443

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL WILSONS DISTRICT</b> c. LENGTH OF STAY IN lb <b>16 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GATEWAY CONVALESCENT HOME</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <b>WASHINGTON</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>132 McCOMAS STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>JOHN WILLIAM SAGER</b>		<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>1</b> Year <b>19 62</b>					
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>NOVEMBER 11, 1889</b>	<b>9. AGE (In years last birthday)</b> <b>82 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>19</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CARPENTERING</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CONSTRUCTION</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>SHENANDOAH JUNCTION W.VA.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>JAMES SOLOMON SAGER</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>FRANCES FLOOK</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>NO</b>		<b>17. INFORMANT</b> <b>MRS. GEORGE MEYER</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>580X</b> <b>Acute Hepatitis</b> <b>Arterio Sclerotic Cardiac Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2 yrs.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 weeks</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1962 to Feb 1, 1962 that (I) (we) last saw the deceased alive on Feb 1, 1962 and that death occurred at 7:30 PM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>David R. Brewer</b>		<b>22b. ADDRESS</b> <b>MAIN ST. CLEAR SPRING MARYLAND</b>		<b>22c. DATE SIGNED</b> <b>FEB 7 '62</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DAVID R BREWER M. D.</b>		<b>22d. ADDRESS</b> <b>MAIN ST. CLEAR SPRING MARYLAND</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>2-3-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL CEMETERY</b>			
<b>23d. LOCATION (City, town or county)</b> <b>HAGERSTOWN MARYLAND</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>SUTER-ROUZER FUNERAL HOME</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 7 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. K...</b>			

MEDICAL CERTIFICATION

1990

END

МАЛЫННЭН ТЭГЭГДЭН

1985-1986



05114

05114

M

I

Handwritten notes and signatures, including a large signature at the bottom right.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02457

02445

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Washington</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>9 Months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Hancock Maryland</u>		d. STREET ADDRESS <u>Hancock Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gate Way Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Mathias Sensel</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>6</u> Year <u>19 62</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1880</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hancock Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Sensel</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca L Weaver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>211.16.4124A</u>		17. INFORMANT <u>Miss Mary Sensel 18 W. High St. Hancock Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>467.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypotensive Sclerosis</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 22, 1962</u> to <u>Feb 6, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 2, 1962</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>David R. Brewer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/8/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>				22d. ADDRESS <u>Clear Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2.9.62</u>		23c. NAME OF CEMETERY OR <del>CHURCH</del> <u>Tonbloway Baptist</u>		23d. LOCATION (City, town & county) (State) <u>Fulton County Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Howe, Hancock, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>EB 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

6450

5

5

5

99

A-3-12

Total Error: 2000000

[illegible]

9-11-54

2

3810

[illegible]

Sub-Part 3 (continued)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02458

## CERTIFICATE OF DEATH

02446

<b>1. PLACE OF DEATH</b> e. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FUNKSTOWN</b>		c. LENGTH OF STAY IN 1b <b>34 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FUNKSTOWN</b>		d. STREET ADDRESS <b>101 EAST MAPLE STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>101 EAST MAPLE STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>WILBUR WELLINGTON SHEPLEY</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>FEBRUARY 14 19 62</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>NOV 12 1894</b>	
<b>9. AGE</b> (In years last birthday) <b>67 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CARMAN</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>RAILROAD</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MYERSVILLE MARYLAND</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>JOHN CLAYTON SHEPLEY</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>SUSAN GROSSNICKLE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>705-10-8646</b>			
<b>17. INFORMANT</b> <b>MRS. WILBUR W SHEPLEY FUNKSTOWN MARYLAND</b>				Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic coronary artery disease</b> (a), stating the underlying cause last. DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ASTHMA</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> yrs yrs							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>none</b>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. none 19 p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
<b>20f. (City or town)</b> <b>none</b>		<b>(County)</b> <b>none</b>		<b>(State)</b> <b>none</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from July 26, 1961, to Feb. 14, 1962, that (I) (we) last saw the deceased alive on Feb. 13, 1962, and that death occurred at 1:30 AM from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Harold R. Tritch Jr</i>				<b>22b. DATE SIGNED</b> <b>2-15-62</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>H R TRITCH JR M. D.</b>				<b>22d. ADDRESS</b> <b>302 N. POTOMAC ST. HAGERSTOWN MARYLAND</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>2-16-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL CEMETERY</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Robert J. Miller</i>				<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Carlton L. Kimes</i>	
<b>SUTHER ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</b>				<b>DATE</b> <b>FEB 19 '62</b>			

VR A15 (4)  
15M 9/60

2222

M

54450

53-21-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

91

(I)

2

MEDICAL CERTIFICATION

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02459 CERTIFICATE OF DEATH 02447

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>1 Mo</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>931 salem Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN RAYMOND SHETRON</b>		First		Middle		Last		4. DATE OF DEATH <b>FEB. 12 1962</b>		Month		Day		Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 14 1893</b>		9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upper Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hag Shoe Co</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Edonville Franklin Co Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Jacob Shetron</b>		14. MOTHER'S MAIDEN NAME <b>Ella Taylor</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>214-09-9238</b>		17. INFORMANT <b>Mrs Maude L. Shetron</b>		Address <b>931 Salem Ave Hagerstown Md</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL THROMBOSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>3 MONTHS</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE HEART DISEASE - PULMONARY EMPHYSEMA</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1-16-1962</b> to <b>2-12-1962</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>2-12-1962</b> , and that death occurred at <b>2:35</b> M, from the causes and on the date stated above.															
22a. SIGNATURE <b>Antonio U. Pallagrosi</b>		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLAGROSI</b>		22d. ADDRESS <b>1500 Pa Ave Hagerstown Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/15/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) <b>Hagerstown Wash Co Md.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Andrew K. Coffman</b>									

03122

M

Washington

Department

801 Wilson Ave

Department of Health

1947

United States

1947

Department of Health

Washington

Department

1947

1947

1947

1947

1947

1947

1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02460

02448

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u>				c. LENGTH OF STAY IN lb <u>25 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport RFD #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Wesley Shipley</u>				4. DATE OF DEATH <u>Feb. 1 19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 28 1889</u>	
9. AGE (in years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Downsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Urilla Hammond</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 14 6690</u>		17. INFORMANT <u>Mrs. Edna Mae Shipley Williamsport Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic heart Disease</u> (c) DUE TO <u>cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>6 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 19 61</u> to <u>Feb. 19 62</u> , that (I) (we) last saw the deceased alive on <u>Jan 21 1962</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edson B. Moody</u>				22b. DATE SIGNED <u>2/2/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edson B. Moody, M. D.</u> <u>145 South Prospect Street</u>				22d. ADDRESS <u>Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

02113

CERTIFICATE OF DEATH

02113



Washington

Maryland

Washington

SE Mrs. David Williamsport

Mr. J. Williamsport

Williamsport and J.

Williamsport and J.

Shipley John Wesley

John

White 22 1888 22 1888

U.S.A. Downsville Md. Labor

William Shipley Willis Hammond

22-18 22-18 Mrs. Jane was Shipley Williamsport Md.

No.

Shipley

Williamsport

Williamsport

Williamsport 22-18 22-18

Williamsport



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. DITTO

I

2

1

DR

M											
1											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02461											
02449											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 31 West Franklin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) VERNON H. SHOVE				4. DATE OF DEATH FEBRUARY - 10 1962				5. SEX MALE			
6. COLOR OR RACE WHITE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH JUNE - 30 - 1899			
9. AGE (In years last birthday) 62 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYEE FAIRCHILD AIRCRAFT				11. BIRTHPLACE (County & State, or foreign country) TILGHMANTON WASH. CO. MD U.S.A.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ISIAH SHOVE				14. MOTHER'S MAIDEN NAME ESTA HAYS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 220-10-3705				17. INFORMANT MRS MARY SHOVE 31 W. FRANKLIN ST HAGERSTOWN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.1 Chronic duodenal ulcer with perforation DUE TO (b) and peritonitis - Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Benign nephrosclerosis, Nodular hyaline arteriosclerosis, Coronary sclerosis, Cachexia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from Feb 4, 1962, to Feb 10, 1962, that (I) (the hospital) saw the deceased alive on Feb 10, 1962, and that death occurred at 12:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Edward W. Ditto III, M.D.				22b. DATE SIGNED 3/11/62				22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, MD			
22d. ADDRESS Hagerstown, MD				22e. REC'D BY REGISTRAR				22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF FEB. 12, 1962				23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY			
23d. LOCATION (City, town or county) SHARPSBURG WASH. CO. MD				23e. REC'D BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR'S SIGNATURE John H. East				24b. ADDRESS BOONSBORO MD				24c. DATE FEB 16 '62			
24d. SIGNATURE				24e. ADDRESS				24f. DATE			

M

13120

CERTIFICATE OF DEATH

02110

and certificate

Ed. A. D. H. III, MD

Hopkinson, 1770

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02462 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02451

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1948</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>807 Interval Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>807 Interval Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Samuel Joseph Simmons</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>21</b> Year <b>1962</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 16, 1894</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>mines</b>		11. BIRTHPLACE (State or foreign country) <b>Accident, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Simmons</b>				14. MOTHER'S MAIDEN NAME <b>Lucinda Aronhalt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-03-2243</b>		17. INFORMANT <b>Clarence Simmons, Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture Of Left Ventricle With Hemopericardium</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial Infarction Left Ventricle Anterior</b> (a), stating the underlying cause last. DUE TO (c) <b>Recent Recent</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2-22-62</b>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2-24-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Accident Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Accident, W. Va.</b>	
23. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 26 1962</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles A. Frank</b>	

MEDICAL CERTIFICATION

THE MAY  
1941



02660

Washington

Lawson

307 1st St. S.W.

Phone

1000

1000

1000

Minor

Minor

Accident, W.D.

George Simmons

Lucinda Simmons

2-10-41-253 (1st and 2nd Sts., S.W.)

*[Handwritten signature]*

2-10-41

Accident, W.D.

George A. Lincoln, 2nd, 1st St., S.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

02463

02452

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Frederick</u></span>																																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>																																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Myersville</u>																																			
				d. STREET ADDRESS <u>Route # 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>THOMAS KELLER SMITH</u>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <u>February 23 1962</u>																																			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1877</u>																																	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.																																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own gen. farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>																																	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																																	
13. FATHER'S NAME <u>Josiah Smith</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Fox</u>																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>219-36-2635</u>																																			
				17. INFORMANT <u>Gorman J. Smith, Myersville, Md. Rt. #2</u>																																			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="6">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> </td> <td colspan="2">           INTERVAL BETWEEN ONSET AND DEATH  <u>4 days</u> </td> </tr> <tr> <td colspan="6">           DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </td> <td colspan="2"></td> </tr> <tr> <td colspan="6">           (b) <u>Bronchial Pneumonia</u> </td> <td colspan="2"> <u>6 days</u> </td> </tr> <tr> <td colspan="6">           DUE TO            (c) <u>Arteriosclerotic Heart Disease</u> </td> <td colspan="2"> <u>10 years</u> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) <u>Bronchial Pneumonia</u>						<u>6 days</u>		DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						<u>10 years</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>																																	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																							
(b) <u>Bronchial Pneumonia</u>						<u>6 days</u>																																	
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						<u>10 years</u>																																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																																			
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																																	
19. I certify that (I) (this hospital) attended the deceased from <u>10-6-61</u> to <u>2-23-62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-23-62</u> , 19 <u>62</u> , and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above.																																							
22a. SIGNATURE <u>Charles F. Hess</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-24-62</u>																																	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M. D.</u>				22d. ADDRESS <u>Smithsburg, Maryland</u>																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 26, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Lutheran</u>		23d. LOCATION (City, town or county) (State) <u>Wolfsville, Frederick Co. Md</u>																																	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>				ADDRESS <u>Myersville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 27 '62</u>																																	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>																																	



Washington

Hagerstown

4 days

Rail-terville

Washington Co. Hospital

Route 4

THOMAS

KEITH

SMITH

February 22

02

Male white

X

April 1, 1947

84

Farmer

own gen. farm

Proctor Co., W. U.S.A.

Joseph Smith

Ellen Fox

no

212-30-2625 Gorman L. Smith, Haverhill, W. H. S.

April 20, 1962 St. Mark's Lutheran Haverhill, W. H. S.

Rev. J. Little, Haverhill, W. H. S.

Proctor Co., W. U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

1  
M  
91  
1

02464

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02453

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Md. State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) BERTIE MILDRED SMOUSE		4. DATE OF DEATH FEB. 15 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Mem's Clothing	9. AGE (In years last birthday) yrs. 82
11. BIRTHPLACE (County & State, or foreign country) Rowlesburg, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel N. Shaffer		14. MOTHER'S MAIDEN NAME Nancy Pugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Florence A. Stouffer Glen Echo, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS - HYPERTENSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 2-16-1962 to 2-15-1962, that (I) (we) last saw the deceased alive on 2-15-1962, and that death occurred at 12 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 Pa Ave Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 19 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

M

02482

02483

CENTRAL W. DEATH

Washington

Harvard

Washington

Harvard

Harvard

Harvard

Eastern N. State Hospital

18 W. Wilson Blvd.

Female

White

Aug. 11, 1888

Glenn

Men's Clothing

Rowlesburg, W. Va.

Daniel E. Shalley

Nancy Tapp

Mrs. Florence A. Stewart, 1800 E. 1st St., W.

Serial

2-15-22

Rose Hill Cemetery

Harveston, Mo.

Boat . . . . .

Don Harveston, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02465

02454

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>70 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown R # 5</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS -----		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Edward</u> Last <u>Snook</u>				4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>19 62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 26, 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lewistown, Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maurice Snook</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Mort</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-2479</u>		17. INFORMANT Address <u>Mrs. Charles R. Decker R # 5 Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>602X</u> DUE TO <u>Compensated abscence of r. kidney</u> Conditions, if any, which gave rise to immediate cause (b) <u>Nephrosclerosis, l. kidney</u> (a), stating the underlying cause last. } DUE TO <u>Removal of Calculus from pelvis of l. kidney</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days -</u> <u>Unknown</u> <u>1 week -</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-5, 1961</u> , to <u>2-6, 1961</u> , that (I) (we) last saw the deceased alive on <u>2-6-1961</u> , and that death occurred at <u>154A</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Hornbaker</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2:7:62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>				22d. ADDRESS <u>154 W. Washington St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Horst</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

(M)

02222

Washington

Washington

70 yrs.

Washington County Hospital

Female

Female

Female

Female

March 28, 1973

Washington, D.C.

Female

Female

Female

Female

214-01-0179 Washington, D.C.

10

John H. Harbinger, M.D.

124 N. Washington Ave.  
Washington, D.C.

21402

Female

Female

Female

Washington, D.C.

Washington, D.C.

02222

Washington

Washington

Washington

March 28, 1973

Washington, D.C.

Female

Female

Female

Female

214-01-0179 Washington, D.C.

10

John H. Harbinger, M.D.

124 N. Washington Ave.  
Washington, D.C.

21402

Female

Female

Female

Washington, D.C.

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02466

02455

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN It <u>12 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. Co. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>142 FAIRGROUND AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>C</u> Last <u>SPIELMAN</u>		4. DATE OF DEATH <u>FEBRUARY - 2 - 1962</u> Month <u>2</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 18, 1878</u> 83 yrs. 2 Months 14 Days	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEAR BOONSBORO WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM STORM</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ADEN P. SPIELMAN</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4200</u> (c) <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis, acute; Cataracts, bilateral; Senile dementia.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 21, 1961</u> to <u>death</u> , 19 <u>1962</u> , that (I) (we) last saw the deceased alive on <u>January 31, 1961</u> , and that death occurred <u>2:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert F. Keadle</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
22e. DATE SIGNED <u>2-3-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 4, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BEAVER CREEK WASH. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 6 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

02155

02155

M

Chloroform, acute; Chloroform, bilateral; Chloroform, bilateral

January 21, 1951

Robert F. Kennedy

January 21, 1951



1  
M  
81  
I  
2  
1  
OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND: STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02467				CERTIFICATE OF DEATH				02456			
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>57 West Franklin St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HARRY PATRICK SPRANKLE</b>						4. DATE OF DEATH <b>Feb 6 1962</b> 19					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 5 1962</b>		9. AGE (In years last birthday) <b>1</b>		IF UNDER 1 YEAR Months Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash Co Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Sprankle</b>						14. MOTHER'S MAIDEN NAME <b>Phyllis Long</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Harry Sprankle 57 W. Franklin St</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Erythroblastosis + atelectasis</b> 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Pulmonary Atelectasis</b> INTERVAL BETWEEN ONSET AND DEATH <b>at birth</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/5</b> , 19 <b>62</b> , to <b>2/5</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> , 19 <b>62</b> , and that death occurred at <b>2/5</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>J. D. Done Jr.</b>						M.D. <b>ATTENDING PHYS. <input checked="" type="checkbox"/></b>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>J. D. Done Jr.</b>						22d. ADDRESS <b>2/6/62</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>						ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thane</b>	

2081271212



02156

02156

Washington, D.C. 20540

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Re: BARRY SPENCER JONES

July 5, 1982

Washington, D.C. 20540

Dear Sir:

Barry Spencer Jones, 37, is a resident of

Washington, D.C.

and is currently residing at 1111 14th Street, N.W.

Very truly yours,

1/2 12 2/3

1/2 12 2/3

1/2 12 2/3

Respectfully,  
Rose Hall University

Andrew K. Gortman, Director

1  
M  
90  
I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02468				02457							
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>2 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GATEWAY CONVALESCENT HOME</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>435 GEORGE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ELLA NMN STANLEY</b>				4. DATE OF DEATH <b>FEBRUARY 13 1962</b>				5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>SHENANDOAH VIRGINIA</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>WASHINGTON COUNTY WELFARE BOARD HAGERSTOWN MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> 4 50.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Sclerosis</b> (c) <b>10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>July 1958</b> to <b>Feb. 13, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 13, 1962</b> and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>David R. Brewer</b> M.D.				22b. DATE SIGNED <b>2/16/62</b>				22c. PHYSICIAN'S NAME (Type) <b>DAVID R. BREWER M. D.</b>			
22d. ADDRESS <b>MAIN STREET CLEAR SPRING MARYLAND</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2-16-62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>			
23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Huns</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 19 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Charles S. Huns</b>			

M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02469

## CERTIFICATE OF DEATH

Reg. Dist. No. 02458

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
c. LENGTH OF STAY IN 1b 4 wks 5 days		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Avalon Manor		d. STREET ADDRESS 493 South Potomac St.	
3. NAME OF DECEASED (Type or print) EDITH LANDIS		4. DATE OF DEATH Month Feb. Day 17 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1879
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lancaster, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ezra F. Landis		14. MOTHER'S MAIDEN NAME Catherine Anthes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Paul Stoner, 493 S. Potomac St., Waynesboro, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome 334X DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease; Calcification Mitral Valve			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-5-1962 to 2-17-1962 that I last saw the deceased alive on 2-17-1962, and that death occurred at 7 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dalton M. Welty		ADDRESS (Street, city or town, state) 998 Potomac Ave	
DATE SIGNED 2-1-62			
PHYSICIAN'S NAME (Type) DALTON M. WELTY		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 20, 1962	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county) (State) Waynesboro Penna.
23. FUNERAL DIRECTOR'S SIGNATURE J. Marlin Poe		ADDRESS Waynesboro, Penna.	
24a. REC'D BY REGISTRAR DATE FEB 21 '62		24b. REGISTRAR'S SIGNATURE Charles S. Kraw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 - be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

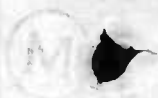
02470

02459

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>386 N. PROSPECT ST.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ETHEL MILDRED STURTZ</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 26 19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/1908</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HAND SEWER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRESS MFG. CO.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>STANLEY PALMER</b>	
14. MOTHER'S MAIDEN NAME <b>HATTIE ITNYER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>214-09-4749</b>		17. INFORMANT <b>MR. ELVIN STURTZ</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arterio Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb 26 1962</b> to <b>Feb 26 1962</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Feb 26 1962</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. Beachley</b>		22b. DATE SIGNED <b>FEB 27 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. Beachley</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/28/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 1 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>S. Hume</b>			

05133

05133



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "OFFICE" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 to be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02471

02460

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>2219 Fairfax Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Louis</u> Last <u>Tiches</u>				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>23</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 23, 1962</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis James Tiches</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Franks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Louis J. Tiches 2219 Fairfax Rd. Hagerstown, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abortion, bilateral</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity + Immaturity</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>62</u> , to <u>2/23</u> , 19 <u>62</u> , that (I) <del>was</del> last saw the deceased alive on <u>2/23</u> , 19 <u>62</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard A. Young M.D.</u>				22b. DATE SIGNED <u>2/24/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Thane</u>	

VR A15 (4)  
15M 7/61

2081334211 Wm. G. Host



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02472

## CERTIFICATE OF DEATH

02461

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>753 Guilford Ave.</u>		d. STREET ADDRESS <u>753 Guilford Ave.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>BLAINE ALFRED TRIMMER</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>February 28 1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>January 24, 1893</u>
<b>9. AGE</b> (In years last birthday) <u>69</u> yrs.		<b>10. AGE</b> (In years last birthday) IF UNDER 1 YEAR: Months Days Hours Min. <u>69</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerical Work</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fairchild</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Oxford, Cumberland Co. Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>Willis Trimmer</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Bernice Myers</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>173-03-3005</u>	
<b>17. INFORMANT</b> <u>Mrs. Fannie M. Trimmer</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction (probable)</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>5 years -</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-10, 1941</u> <b>to</b> <u>2-28, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12-22, 1961</u> <b>and that death occurred at</b> <u>1:30 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>John H. Hornbaker</u>		<b>22b. DATE SIGNED</b> <u>2:28:62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>John H. Hornbaker, M.D.</u>		<b>22d. ADDRESS</b> <u>154 W. Washington St., Hagerstown, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/3/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Lawn Mem. Gardens</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Hagerstown, Maryland.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u>		<b>25a. REC'D BY REGISTRAR</b> <u>5 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Andrew K. Coffman</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>Andrew K. Coffman</u>	

02172

02172



154 W. Washington St.,  
Hagerstown, Md.

John H. Hombaker, M.D.

2:28:52



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02473

02463

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Antietam Furnace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Antietam Furnace</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. STREET ADDRESS <u>Sharpsburg Md RFD #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharpsburg Md RFD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Minnie Florence Tucker</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>11</u> Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (Country & State, or foreign country) <u>Antietam Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Jacob Boyer</u>	
14. MOTHER'S MAIDEN NAME <u>Annie (Unknown)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Alta Mae Reynolds Fairplay Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute right sided heart failure</u> 422.1 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Sharpsburg Md.</u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1</u> , 19 <u>61</u> , to <u>2/11</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Feb. 2</u> , 19 <u>62</u> , and that death occurred at <u>6</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter H. Shealy</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>2/12/62</u> 22d. ADDRESS <u>Sharpsburg, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>Feb. 13-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	
23d. LOCATION (City, town or county) <u>Sharpsburg Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>			

(M)

02473

02473

Washington

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02464

02474

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown,</b> c. LENGTH OF STAY IN 1b <b>21 dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Md. State Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rt. # 1 Oldtown</b> d. STREET ADDRESS <b>Sunny Flats</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Mae</b> Last <b>Twigg</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15, 1879</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>82</b>	IF UNDER 24 HRS. Hours <b>82</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Allegany Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Koontz</b>		14. MOTHER'S MAIDEN NAME <b>( Unknown ) Skelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Myrtle Redinger</b>		Address <b>Rt. # 1 Oldtown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of hip, right</b> (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>(1) Agranulocytosis. (2) General arteriosclerosis. (3) Nephrosclerosis. (4) Parkinsonism.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While walking in home fell fracturing hip</b> 20c. TIME OF INJURY Month, Day, Year <b>12-5-1961</b> Hour a.m. p.m. <b>12-5-1961</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Home</b> 20f. (City or town) <b>Oldtown</b> (County) <b>Allegany</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H. Wayne George</b> EXAMINER'S NAME (Type) <b>H. Wayne George</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/3/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Oldtown, Maryland</b>	
23. FUNERAL DIRECTOR <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>5 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>	

VS. A15ME  
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your reference. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE  
OF NEW YORK



IN SENATE  
JANUARY 1, 1901

REPORT  
OF THE

COMMISSIONER  
OF THE LAND OFFICE

IN RESPONSE  
TO A RESOLUTION  
PASSED BY THE SENATE  
JUNE 1, 1899

ALBANY:

WILLIAM B. EDEY,  
PRINTER.

1901.

1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

90

1

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02475

## CERTIFICATE OF DEATH

02465

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>5 MOS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GATEWAY CONVALESCENT HOME</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>2523 PENNSYLVANIA AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES HENRY UNGER</b>				4. DATE OF DEATH <b>FEBRUARY 16 19 62</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 6 1883</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN COUNTY PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ABRAM UNGER</b>				14. MOTHER'S MAIDEN NAME <b>MAY POPER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-26-5296A</b>		17. INFORMANT <b>MRS. HARLAN SCOTT HAGERSTOWN MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Cerebral Apoplexy</b> DUE TO (b) <b>Arterial Sclerosis</b> DUE TO (c) <b>Prostatic resection</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 14, 1961</b> to <b>Feb 16, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 16, 1962</b> and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>David R Brewer</b>				22b. DATE SIGNED <b>2/20/62</b>		22c. PHYSICIAN'S NAME (Type) <b>DAVID R BREWER M. D.</b>	
22d. ADDRESS <b>MAIN STREET CLEAR SPRING MARYLAND</b>				22e. REC'D BY REGISTRAR <b>FEB 26 '62</b>			
22f. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>				22g. SUPERVISOR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-19-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M. Kauer</b>				24b. ADDRESS <b>SUPER-BOUZER FUNERAL HOME HAGERSTOWN MARYLAND</b>			



M

1

02105

02105

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

02105

WASHINGTON

WASHINGTON

WASHINGTON

02105

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

02105

WASHINGTON

WASHINGTON

02105

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Downsville</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			d. STREET ADDRESS <b>103 W. Franklin St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Woburn Manor Boarding Home</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Martin Wagonhouser</b>					4. DATE OF DEATH Month Day Year <b>Feb. 21 19 62</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 15, 1873</b>		9. AGE (In years last birthday) <b>88</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ice Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Waynesboro, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-2249</b>		17. INFORMANT Address <b>Mrs. Ethel Ralls 1710 Sherman Ave. Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. MYOCARDIA L IN FIBRATION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/21/62</b> to <b>2/21/62</b> , that (I) (we) last saw the deceased alive on <b>2/21/62</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Ralph F. Young</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>2/23/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph F. Young M.D.</b>					22d. ADDRESS <b>101 E. Potomac St. Williamsport, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/24/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Hagerstown, Md.</b> <b>Wm. C. Horst</b>					25a. REC'D BY REGISTRAR <b>FEB 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		

(M)

17330

Washington

James L. Jones

James L. Jones

James

James

James

James

James

James

James L. Jones

James L. Jones

James

James

James L. Jones

James L. Jones

James L. Jones

James L. Jones

James L. Jones

James L. Jones

James L. Jones

James L. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/60

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>M.</p> <p>02477</p> </div> <div> <p>1</p> <p>02467</p> </div> </div> <div style="text-align: center;"> <p>1</p> <p>M.</p> <p>02477</p> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>15 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ROUTE # 6 HAGERSTOWN MARYLAND</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <b>WASHINGTON</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b> d. STREET ADDRESS <b>ROUTE # 6 HAGERSTOWN MARYLAND</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <b>ELIZABETH BESSIE WALICK</b>						<b>4. DATE OF DEATH</b> <b>FEBRUARY 15 19 62</b>						
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>SEPTEMBER 1 1879</b>		<b>9. AGE</b> (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>WASHINGTON COUNTY MD</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WASHINGTON COUNTY MD</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				
<b>13. FATHER'S NAME</b> <b>MONROE ZIMMERMAN</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>LEAH BITNER</b>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MRS. RUTH GREEN</b>		<b>Address</b> <b>ROUTE #6 HAGERSTOWN MD</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500 Hemia</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>-</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b> <b>years</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>												
<b>18a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>18b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1958</b> <b>to</b> <b>15 Feb</b> <b>1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>14 Feb</b> <b>1962</b> <b>and that death occurred at</b> <b>3:30 PM</b> <b>from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <b>D Wilson</b>						<b>22b. DATE SIGNED</b> <b>15 Feb 1962</b>						
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>D WILSON M. D.</b>						<b>22d. ADDRESS</b> <b>135 N. POTOMAC ST HAGERSTOWN MARYLAND</b>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>2-17-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL CEMETERY</b>			<b>23d. LOCATION (City, town or county)</b> <b>(State)</b> <b>HAGERSTOWN MARYLAND</b>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>SUTER-ROUZER FUNERAL HOME</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 19 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Kenna</b>				

MEDICAL CERTIFICATION

02237

02237

M

WASHINGTON

MARYLAND

WASHINGTON

HIGH MARYLAND

12 YEARS

HIGH MARYLAND

ROUTE 1 6 HARBOR MARYLAND

ROUTE 1 6 HARBOR MARYLAND

22 22 22 22 22 22 22 22 22 22

22 22 22 22 22 22 22 22 22 22

22 22 22 22 22 22 22 22 22 22

22 22 22 22 22 22 22 22 22 22

WASHINGTON COUNTY MD

WASHINGTON COUNTY MD

WASHINGTON COUNTY MD

WASHINGTON COUNTY MD

ROUTE 1 6 HARBOR MARYLAND

ROUTE 1 6 HARBOR MARYLAND

ROUTE 1 6 HARBOR MARYLAND

12211 ROUTE 1 6 HARBOR MARYLAND

12211 ROUTE 1 6 HARBOR MARYLAND

WASHINGTON COUNTY MD

WASHINGTON COUNTY MD

WASHINGTON COUNTY MD

WASHINGTON COUNTY MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02478

## CERTIFICATE OF DEATH

02468

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING</b> c. LENGTH OF STAY IN lb <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>S. MARTIN ST.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. <del>STATE</del> <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING</b> d. STREET ADDRESS <b>S. MARTIN</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BERTHA MARIE WARNER</b>		4. DATE OF DEATH <b>FEB. 4, 19 62</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/5/1886</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK G. WARNER</b>		14. MOTHER'S MAIDEN NAME <b>ROSA FELLINGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>212-38-9606</b>	
17. INFORMANT <b>JOSEPHINE HIGGINS</b>		Address <b>CLEAR SPRING, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>181.0</b> DUE TO <b>Myemia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma of bladder, urinary</b> DUE TO (c) <b>1 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arterio sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 30, 1961</b> to <b>Jan 25, 1962</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Jan 25, 1962</b> , and that death occurred at <b>11:55 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph C. Crisp M.D.</b>		22b. DATE SIGNED <b>2-5-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOS C. CRISP MD</b>		22d. ADDRESS <b>115 King St. Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/7/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CLEAR SPRING, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret K. Rowland</b>		25a. REC'D BY REGISTRAR <b>FEB 8 '62</b>	
ADDRESS <b>CLEAR SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



8750

0000-00-0000

08-00-H243

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02479					02469				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>WASHINGTON</u>					a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				
c. LENGTH OF STAY IN 1b <u>3 DAYS</u>					d. STREET ADDRESS <u>242 SOUTH MULBERRY ST.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. Co. HOSPITAL</u>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ANDEA LYN WILES</u>					4. DATE OF DEATH <u>FEBRUARY - 24 1962</u>				
5. SEX <u>FEMALE</u>					6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>FEBRUARY 21-1962</u>				
9. AGE (In years last birthday) <u>0</u> yrs. <u>0</u> months <u>3</u> days					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. Co. MD. U.S.A.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>WILLIAM WILES</u>					14. MOTHER'S MAIDEN NAME <u>MAXINE VIRGINIA SHANK</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>					16. SOCIAL SECURITY NO. <u>242 S. MULBERRY ST. HAGERSTOWN MD (FATHER)</u>				
17. INFORMANT <u>WILLIAM WILES</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Congenital Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>754.5</u> DUE TO <u></u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>					20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>2-21-62</u> to <u>2-24-62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-23-62</u> , 19 <u>62</u> , and that death occurred at <u>12:30 A</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles F. Hess</u> M.D.					22b. DATE SIGNED <u>2-24-62</u>				
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, MD.</u>					22d. ADDRESS <u>Smithsburg, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>FEB. 26, 1962</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>					23d. LOCATION (City, town or county) (State) <u>BEAVER CREEK WASH. Co. MD</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>					25a. REC'D BY REGISTRAR <u>DATE FEB 28 '62</u>				
25b. REGISTRAR'S SIGNATURE <u>Boonsboro MD</u>									

2081211215

(M)

05430

05430

Wagon, 171

Wagon, 171

Wagon, 171

Hagerstown

Hagerstown

Hagerstown

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Wagon, 171

Boonboro MD

John D. Galt

Beaver Creek Cemetery, Beaver Creek, Pa.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02480

1. MARYLAND  
02470

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. STATE		b. COUNTY	
WASHINGTON		MARYLAND		MARYLAND		WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
HAGERSTOWN		11 YEARS		HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
1316 SALEM AVENUE				1316 SALEM AVENUE			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
VERA		JEAN		WISHARD		4. DATE OF DEATH	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
JANUARY 19 1928		9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
WATRESS		RESTAURANT		BIG SPRINGS MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HERBERT McALLISTER				LIDA SHANK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
NO				215-26-8452			
17. INFORMANT				Address			
FRED H WISHARD HAGERSTOWN MARYLAND							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gun shot Wounding entire head</u> (b) <u>gun shot</u> (c) <u>gun shot</u>							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gun shot</u> (c) <u>gun shot</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Home on leave from U.S. Marines</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH. <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>gun shot wound of head</u>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>2-18-62</u> 4 <u>PM</u>							
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>							
20f. (City or town) (County) (State) <u>Hagerstown Washington Md</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 215 W WASHINGTON ST							
Address (Street, city, town, or county) HAGERSTOWN MARYLAND							
DATE SIGNED <u>2-18-62</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)							
22b. DATE THEREOF							
22c. NAME OF CEMETERY OR CREMATORY							
22d. LOCATION (City, town, or country) (State)							
BURIAL 2-21-62 CEDAR LAWN MEMORIAL GARDEN HAGERSTOWN MARYLAND							
23. FUNERAL DIRECTOR							
ADDRESS							
24a. REC'D BY REGISTRAR							
24b. REGISTRAR'S SIGNATURE							
DATE FEB 26 '62 <u>Arthur S. Thomas</u>							

1  
FOR STATE  
HEALTH DEPT.

(M)

(1)

02120

02120

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
SAN FRANCISCO, CALIFORNIA

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02481

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN b <b>50 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>125 N. Conococheague Street</b>		d. STREET ADDRESS <b>125 N. Conococheague St.</b>	
3. NAME OF DECEASED (Type or print) <b>David</b> First <b>Walt</b> Middle <b>Young</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7 1870</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Downsville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Jeremiah Young</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 18 2344</b>	
17. INFORMANT <b>Mr. Lester Young</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>AC. myocardial infarction</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/22/62</b> to <b>2/22/62</b> , that (I) (we) last saw the deceased alive on <b>2/22/62</b> , and that death occurred at <b>2/22/62</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Lester Young</b>		22b. DATE SIGNED <b>2/24/62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 25 -62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery.</b>		23d. LOCATION (City, town or county) (State) <b>Williamsport Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Williamsport, Md</b>		25a. REC'D BY REGISTRAR <b>FEB 27 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			





12290

Washington

Little Rock

122 N. Conococheague Street

David

Walt

Young

Nov. 7 1890

of

Douglasville Ga.

Douglas Co.

Lebanon

Lebanon Young

Lebanon Young

Sold for

200 is sold in

*[Faint handwritten text, possibly a signature or address]*

2-11-12

*[Large handwritten signature or name]*

Feb. 22 - 1892 - 1893

Washington

1891

*[Faint handwritten text at the bottom]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02482

02472

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Yr</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		d. STREET ADDRESS <b>1004 Linwood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA GRACE ZIMMERMAN</b>		First		Middle		Last		4. DATE OF DEATH Month <b>FEB.</b> Day <b>8</b> Year <b>1962</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 30 1873</b>		9. AGE (In years last birthday) <b>88 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b>		IF UNDER 24 HRS. Hours <b>8</b> Min. <b>8</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Frederick Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Calvin A. Rhodes</b>		14. MOTHER'S MAIDEN NAME <b>Susan C. Steiner</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Elizabeth Bragunier</b>		Address <b>1004 Linwood Rd Hagerstown Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of breast, rt., recurrent</b> DUE TO (c) <b>Diabetes Mellitus.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>18 years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>9-27-1961 to 2-8-1962</b>		(County) <b>2-8-1962</b>		(State) <b>1962</b>		21. I certify that (I) (the undersigned) attended the deceased from <b>9-27-1961</b> to <b>2-8-1962</b> that (I) (the undersigned) last saw the deceased alive on <b>2-8-1962</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Feb. 9, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>Victor L. Ramos, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope Cemetery</b>		23d. LOCATION (City, town or county) <b>Woodsboro Fred Co Md</b>		(State) <b>Md</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. DATE <b>FEB 13 '62</b>		25d. SIGNATURE <b>Arthur S. Kline</b>		25e. ADDRESS <b>Hagerstown Md.</b>		25f. CITY OR TOWN <b>Hagerstown Md.</b>		25g. STATE <b>Md.</b>	

MEDICAL CERTIFICATION

22500

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>7 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Martin Manor Rest Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rural</b> d. STREET ADDRESS <b>445 Edgewood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward Bomberger Zimmerman</b>		4. DATE OF DEATH <b>February 11 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1869</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Roads Com.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Near Williamsport, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward R. Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Bomberger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-9229</b>	
17. INFORMANT <b>Mrs. Emma T. Zimmerman</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Benign Prostatic Hypertrophy</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 5 1962</b> to <b>Feb 11 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 8 1962</b> , and that death occurred at <b>12:45 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul Harrison</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>		22d. ADDRESS <b>318 N. Potomac St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-13-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown, Md.</b>		25. REC'D BY REGISTRAR <b>FEB 15 '62</b>	
25a. ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

VR A15 (4)  
15M 9/60

Harrison



02173

02173

Arthur Honor Best Home  
412 Jackson Drive

Edward  
Honor Best Home  
412 Jackson Drive

Edward N. Zimmerman  
412 Jackson Drive

412 Jackson Drive  
412 Jackson Drive

412 Jackson Drive

412 Jackson Drive

412 Jackson Drive  
412 Jackson Drive

412 Jackson Drive